

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00100

REPLACEMENT: 2210 2-5-57 - Dr. Lovitt

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendship		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendship	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First William Middle Thomas Last Armiger			4. DATE OF DEATH Month Jan. Day 1 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/97	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter	10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (State or foreign country) Friendship	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME JOSEPH F. ARMIGER	14. MOTHER'S MAIDEN NAME AGNES V. ATWELL
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW 1	16. SOCIAL SECURITY NO. none	17. INFORMANT AGNES V. ARMIGER Address 212 Cedar drive DC 22
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarct due to hypertensive arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and find that death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE William V. Lovitt, Jr. M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 2/6/57
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/6/57	22c. NAME OF CEMETERY OR CREMATORY Union Chapel	22d. LOCATION (City, town, or county) (State) McKendree Md.
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23. FUNERAL DIRECTOR'S SIGNATURE BERNARD HARDESTY ADDRESS GALESVILLE MD.	24a. REC'D BY REGISTRAR 1/10/57	24b. REGISTRAR'S SIGNATURE WM. J. FRENCH
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MAX LAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased WILLIAM V. BRYAN		Sex Male		Age 35		Race White		Date of Birth 1922	
Place of Birth Baltimore, Md.		Usual Residence Baltimore, Md.		Occupation Salesman		Cause of Death Myocardial infarction		Manner of Death Natural	
Signature of Medical Examiner [Signature]		Signature of Coroner [Signature]		Signature of Registrar [Signature]		Signature of Witness [Signature]		Signature of Witness [Signature]	
Date of Death Feb 3, 1957		Time of Death 10:00 AM		Place of Death Home		Hospital None		Physician None	
Medical History None		Social History None		Family History None		Postmortem Examination None		Remarks None	

RECEIVED
 FEB 8 1957
 BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

133

CERTIFICATE OF DEATH

00101

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3401-4 2637 France Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Baltimore City		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Banks Last Banks				4. DATE OF DEATH Month 1 Day 3 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
9. AGE (In years last birthday) 67? yrs.		IF UNDER 1 YEAR Months 67? Days 67? Hours 67? Min. 67?		IF UNDER 24 HRS. Months 67? Days 67? Hours 67? Min. 67?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Solomon Banks				14. MOTHER'S MAIDEN NAME Mary Banks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records Address Crownsville State Hospital Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive, arteriosclerotic heart disease DUE TO (c) Hypostatic Pneumonia							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/24 , 19 56 , to 1/3 , 19 57 , that I last saw the deceased alive on 1/3 , 19 57 , and that death occurred at 10:40 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 1/3/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-5-57		22c. NAME OF CEMETERY OR CREMATORY MT. CARMEL		22d. LOCATION (City, town, or county) (State) Baltimore			
23. FUNERAL DIRECTOR'S SIGNATURE E. O. Wilson ADDRESS				24a. REC'D BY REGISTRAR 1/18/57 DATE		24b. REGISTRAR'S SIGNATURE L. M. Joyce	

CERTIFICATE OF DEATH

PLACE TO BE FILLED BY THE REGISTRAR		DATE OF DEATH	
COUNTY OF BALTIMORE		JAN 21 1957	
NAME OF DECEASED		AGE	
JOHN J. JONES		65	
SEX		MALE	
RACE		WHITE	
BIRTH DATE		JAN 1 1892	
BIRTH PLACE		BALTIMORE, MARYLAND	
EDUCATION		HIGH SCHOOL	
OCCUPATION		LABORER	
MARRIAGE		MARRIED	
DATE OF MARRIAGE		JAN 15 1920	
NAME OF SPOUSE		MARY J. JONES	
DATE OF DEATH		JAN 21 1957	
PLACE OF DEATH		HOME	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF REGISTRAR		[Signature]	
DATE OF REGISTRATION		JAN 21 1957	

BUREAU V. B.

JAN 21 1957

RECEIVED

RECEIVED
JAN 21 1957
BALTIMORE, MARYLAND
STATE DEPARTMENT OF HEALTH

134

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade				c. LENGTH OF STAY IN 1b Baltimore 3y 0m 4d			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital				d. STREET ADDRESS 1323 West Mountroyal Avenue			
3. NAME OF DECEASED (Type or print) First TIMOTHY Middle (NMN) Last BEISEL				4. DATE OF DEATH Month January Day 30 Year 19 57			
5. SEX Male	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 17 March 1895		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months 13 Days 13 Hours — Min. —	IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army		11. BIRTHPLACE (State or foreign country) Hazleton, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Present		16. SOCIAL SECURITY NO. U. S. Army		17. INFORMANT U. S. Army Ft. Meade Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Calcific Aortic Stenosis DUE TO (c) —						INTERVAL BETWEEN ONSET AND DEATH Several yrs 11	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour — a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Fort George G. Meade, Maryland		(County) (State)	
21. I certify that I attended the deceased from 10 Jan 19 57 , to 30 Jan 19 57 , that I last saw the deceased alive on 30 Jan 19 57 , and that death occurred at 1230P M. from the causes and on the date stated above.							
ACTUAL SIGNATURE John F. McDonnell M.D.				ADDRESS (Street, city or town, state) U. S. ARMY HOSPITAL		DATE SIGNED 30 Jan 57	
PHYSICIAN'S NAME (Type) JOHN F. McDONNELL, M.D., MAJ., MC.				Fort George G. Meade, Maryland			
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
BURIAL	2-4-57	Arlington		Wash D.C.			
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM COOKE, Inc. Baltimore, Maryland				24a. REC'D BY REGISTRAR DATE 30 Jan 57		24b. REGISTRAR'S SIGNATURE W. L. SAYLOR, 1ST LT, MSC	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

RECEIVED
FEB 4 1957
BUREAU V. 2

NAME OF DECEASED [Faint text, possibly "JOHN J. SMITH"]		SEX [Faint text, possibly "M"]		AGE [Faint text, possibly "45"]	
DATE OF DEATH [Faint text, possibly "FEB 3 1957"]		PLACE OF DEATH [Faint text, possibly "HOME"]		COUNTY [Faint text, possibly "BALTIMORE"]	
CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]		MANNER OF DEATH [Faint text, possibly "NATURAL"]		PLACE OF BIRTH [Faint text, possibly "NEW YORK"]	
DATE OF BIRTH [Faint text, possibly "JUL 15 1912"]		PLACE OF BIRTH [Faint text, possibly "NEW YORK"]		COUNTY OF BIRTH [Faint text, possibly "NEW YORK"]	
DATE OF DEATH [Faint text, possibly "FEB 3 1957"]		PLACE OF DEATH [Faint text, possibly "HOME"]		COUNTY OF DEATH [Faint text, possibly "BALTIMORE"]	
CAUSE OF DEATH [Faint text, possibly "HEART DISEASE"]		MANNER OF DEATH [Faint text, possibly "NATURAL"]		PLACE OF BIRTH [Faint text, possibly "NEW YORK"]	
DATE OF BIRTH [Faint text, possibly "JUL 15 1912"]		PLACE OF BIRTH [Faint text, possibly "NEW YORK"]		COUNTY OF BIRTH [Faint text, possibly "NEW YORK"]	

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>407 W. Maple Road</u>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN H. BLANDIN</u>				4. DATE OF DEATH Month Day Year <u>January 16, 1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15/1905</u>	9. AGE (In years last birthday) <u>51</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Elec. Maintanance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Friendship Airport.</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clark W. Blandin</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude E. Hart</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>26-130 214 01 5939</u>		17. INFORMANT Address <u>Mrs. Alice M. Blandin Same As #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> DUE TO (b) <u>with Mestastasis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>6 mo. plus</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 31/1956</u> to <u>Jan. 16/1957</u> , that I last saw the deceased alive on <u>Jan. 16/1957</u> , and that death occurred at <u>6: P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. Milton Linthicum</u>				ADDRESS (Street, city or town, state) <u>106 W. Maple Rd.</u> DATE SIGNED <u>1/17/57</u>			
PHYSICIAN'S NAME (Type) <u>C. Milton Linthicum</u>				Linthicum Heights, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 21 1957

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape Lock Haven</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape Lock Haven</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Poplar + Oak Aves</u>		e. STREET ADDRESS <u>Poplar + Oak Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Eula</u> Middle <u>G.</u> Last <u>Bohn</u>		4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 8 - 1893</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>63</u> Days <u>63</u>	IF UNDER 24 HRS. Hours <u>63</u> Min. <u>63</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State and foreign country) <u>Kave Springs Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Mc Cray</u>		14. MOTHER'S MAIDEN NAME <u>Edaline Moody</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Joseph H. Fisher</u>	
17. INFORMANT <u>Joseph H. Fisher</u>		Address <u>(3)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>1/24/57</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>1-25-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fair View</u>	22d. LOCATION (City, town, or county) (State) <u>Roanoke Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 1/29/57</u>		24b. REGISTRAR'S SIGNATURE <u>- O. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

JAN 30 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 MARKET St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>L</u> Last <u>BOUCHER</u>				4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-21-1893</u>	
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Court Crier Md.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>County Appeals</u>		11. BIRTHPLACE (State or foreign country) <u>ANNAPOLIS MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>WILLIAM MOSS BOUCHER</u>				14. MOTHER'S MAIDEN NAME <u>ROSE McBEE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>World War I</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>LOTTIE REVELL</u>				Address <u>812 CHESAPEAKE AVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec. 20</u> , 19 <u>56</u> to <u>Jan 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 23</u> , 19 <u>57</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James R. Martin</u>				ADDRESS (Street, city or town, state) <u>6 Shaw St. Annapolis, Md.</u>			
DATE SIGNED <u>Jan 24/57</u>							
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>				ADDRESS <u>6 SHAW ST. ANNAPOLIS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-26-57</u>		<u>St Marys</u>		<u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Saylor Sons</u>				ADDRESS <u>Annapolis Md.</u>			
24a. REC'D BY REGISTRAR DATE <u>1/24/57</u>				24b. REGISTRAR'S SIGNATURE <u>V. Ormick</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF BURIAL PLACE	
16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF CLERK		21. SIGNATURE OF SHERIFF	
22. SIGNATURE OF DEPUTY SHERIFF		23. SIGNATURE OF CONSTABLE		24. SIGNATURE OF JAILER	
25. SIGNATURE OF PRISON WARDEN		26. SIGNATURE OF PRISON CHIEF		27. SIGNATURE OF PRISON CLERK	
28. SIGNATURE OF PRISON DOCTOR		29. SIGNATURE OF PRISON NURSE		30. SIGNATURE OF PRISON CHAPLAIN	
31. SIGNATURE OF PRISON SHERIFF		32. SIGNATURE OF PRISON JAILER		33. SIGNATURE OF PRISON CLERK	
34. SIGNATURE OF PRISON DOCTOR		35. SIGNATURE OF PRISON NURSE		36. SIGNATURE OF PRISON CHAPLAIN	
37. SIGNATURE OF PRISON SHERIFF		38. SIGNATURE OF PRISON JAILER		39. SIGNATURE OF PRISON CLERK	
40. SIGNATURE OF PRISON DOCTOR		41. SIGNATURE OF PRISON NURSE		42. SIGNATURE OF PRISON CHAPLAIN	
43. SIGNATURE OF PRISON SHERIFF		44. SIGNATURE OF PRISON JAILER		45. SIGNATURE OF PRISON CLERK	
46. SIGNATURE OF PRISON DOCTOR		47. SIGNATURE OF PRISON NURSE		48. SIGNATURE OF PRISON CHAPLAIN	
49. SIGNATURE OF PRISON SHERIFF		50. SIGNATURE OF PRISON JAILER		51. SIGNATURE OF PRISON CLERK	
52. SIGNATURE OF PRISON DOCTOR		53. SIGNATURE OF PRISON NURSE		54. SIGNATURE OF PRISON CHAPLAIN	
55. SIGNATURE OF PRISON SHERIFF		56. SIGNATURE OF PRISON JAILER		57. SIGNATURE OF PRISON CLERK	
58. SIGNATURE OF PRISON DOCTOR		59. SIGNATURE OF PRISON NURSE		60. SIGNATURE OF PRISON CHAPLAIN	
61. SIGNATURE OF PRISON SHERIFF		62. SIGNATURE OF PRISON JAILER		63. SIGNATURE OF PRISON CLERK	
64. SIGNATURE OF PRISON DOCTOR		65. SIGNATURE OF PRISON NURSE		66. SIGNATURE OF PRISON CHAPLAIN	
67. SIGNATURE OF PRISON SHERIFF		68. SIGNATURE OF PRISON JAILER		69. SIGNATURE OF PRISON CLERK	
70. SIGNATURE OF PRISON DOCTOR		71. SIGNATURE OF PRISON NURSE		72. SIGNATURE OF PRISON CHAPLAIN	
73. SIGNATURE OF PRISON SHERIFF		74. SIGNATURE OF PRISON JAILER		75. SIGNATURE OF PRISON CLERK	
76. SIGNATURE OF PRISON DOCTOR		77. SIGNATURE OF PRISON NURSE		78. SIGNATURE OF PRISON CHAPLAIN	
79. SIGNATURE OF PRISON SHERIFF		80. SIGNATURE OF PRISON JAILER		81. SIGNATURE OF PRISON CLERK	
82. SIGNATURE OF PRISON DOCTOR		83. SIGNATURE OF PRISON NURSE		84. SIGNATURE OF PRISON CHAPLAIN	
85. SIGNATURE OF PRISON SHERIFF		86. SIGNATURE OF PRISON JAILER		87. SIGNATURE OF PRISON CLERK	
88. SIGNATURE OF PRISON DOCTOR		89. SIGNATURE OF PRISON NURSE		90. SIGNATURE OF PRISON CHAPLAIN	
91. SIGNATURE OF PRISON SHERIFF		92. SIGNATURE OF PRISON JAILER		93. SIGNATURE OF PRISON CLERK	
94. SIGNATURE OF PRISON DOCTOR		95. SIGNATURE OF PRISON NURSE		96. SIGNATURE OF PRISON CHAPLAIN	
97. SIGNATURE OF PRISON SHERIFF		98. SIGNATURE OF PRISON JAILER		99. SIGNATURE OF PRISON CLERK	
100. SIGNATURE OF PRISON DOCTOR		101. SIGNATURE OF PRISON NURSE		102. SIGNATURE OF PRISON CHAPLAIN	

RECEIVED
JAN 25 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00106

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS 10</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>803 Glendon Ave.</u>				d. STREET ADDRESS <u>803 GLENDON AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>C</u> Last <u>BROWN</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>		IF UNDER 24 MRS. Hours <u>14</u> Min. <u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN (STATE)</u>				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) <u>COCKEYSVILLE MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Charles E. Brown</u>				14. MOTHER'S MAIDEN NAME <u>Priscilla Gill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Nzom, Marcott</u> Address <u>(2)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun that wound neck</u> DUE TO <u>976x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Sudden</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self inflicted gun that wound</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. (City or town) 				(County) 		(State) 	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. INHART</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) <u>Annapolis MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Lee</u>				24a. REC'D BY REGISTRAR DATE <u>10/16/57</u>			
24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

JAN 17 1967

RECEIVED

102
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>W.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>29 Pinkney St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William H Brown</u>				4. DATE OF DEATH Month <u>11</u> Day <u>25</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cal</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-15-1887</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>City of Anna. Birdsallville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Brown</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Foote</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>1940</u>				16. SOCIAL SECURITY NO. <u>11740</u>			
17. INFORMANT <u>Agnes Brown - Annapolis, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerosis</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-23-57</u> , 19 <u>57</u> , to <u>11-25-57</u> , 19 <u>57</u> , that I lost the deceased alive on <u>1-23-57</u> , 19 <u>57</u> , and that death occurred at <u>4 1/2</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 L. E. Graham St</u> DATE SIGNED							
ACTUAL SIGNATURE <u>G. T. Allen</u>				M.D. <u>G. T. Allen</u>			
PHYSICIAN'S NAME (Type) <u>G. T. Allen</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-29-57</u>		<u>Brewer Hill</u>		<u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Annapolis, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>1-29-57</u>	
						24b. REGISTRAR'S SIGNATURE <u>Wm. J. Lench</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>11. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>12. DATE OF DEATH [Faint text]</p>	
<p>13. PLACE OF DEATH [Faint text]</p>		<p>14. TIME OF DEATH [Faint text]</p>	
<p>15. SIGNATURE OF WITNESS [Faint text]</p>		<p>16. SIGNATURE OF DECEASED [Faint text]</p>	

BUREAU V. 5

JAN 30 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00109

Reg. Dist. No. 21

103

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Churchton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Dudley Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>WOODROW</u> Last <u>CHAPMAN</u>		4. DATE OF DEATH Month <u>January</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1913</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mach.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Chapman</u>		14. MOTHER'S MAIDEN NAME <u>Rose Carmeon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. C.W. Chapman - Wife - Same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Sudden</u> (a), stating the underlying cause last. (c) <u> </u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>7:40</u> Hour <u>XX</u> p. m. <u>Jan 17</u> 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Elmer G. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Elmer G. Linhardt MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>January 21, 57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hebron Comet</u>		22d. LOCATION (City, town, or county) (State) <u>Winchester, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>Annapolis, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Am. J. French</u>	
DATE <u>JAN 21 1957</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is mostly blank, with some faint markings and a small rectangular stamp in the lower right quadrant.

RECEIVED
JAN 21 1957
BUREAU V. 2

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Abbe Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jessups</u>		c. LENGTH OF STAY IN lb <u>Few seconds</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2000 Feet east of route 8 175</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Fort Meade</u>	
		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Edward Collins</u>		4. DATE OF DEATH <u>January 21st, 1957</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/6/28</u>
9. AGE (In years last birthday) <u>28</u> YRS.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sergeant in the U.S. Army</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Gilbert, S. Carolina.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes at present.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Fort Meade Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Comp. comm. fracture of left forearm</u> (c) <u>Sudden</u> DUE TO (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile hit a telephone post and turned over.</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:55 A.M. 1/21/57</u> 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 8 Md.</u>		20f. (City or town) <u>Jessups A.A.</u> (County) <u>Md.</u> (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/21/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>13319 Phillips</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Palmetta Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Columbia, S. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips</u>		ADDRESS <u>1808 N. Monroe St. Baltimore, Md</u>	
24a. REC'D BY REGISTRAR <u>W.L. SAILOR</u>		24b. REGISTRAR'S SIGNATURE <u>1/Lt MSC</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

JAN 23 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G209 1-21-57 et

CERTIFICATE OF DEATH

00111

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>ANNAPOLIS</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Bowell Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Josephine Cortez</u>				4. DATE OF DEATH Month Day Year <u>Jan 7 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 2 1900</u>	9. AGE (In years last birthday) <u>56 1/2</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>✓</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Cortez</u>				14. MOTHER'S MAIDEN NAME <u>Olivia Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary E Parker</u>		Address <u>Bowell Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease & Hypertension</u> (c) <u>Extreme Dehydration</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>Yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1/2</u> , 1957, to <u>1/8</u> , 1957, that I last saw the deceased alive on <u>1/7</u> , 1957, and that death occurred at <u>7 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Mannis Klawans</u> M.D. <u>31 Smith St Annapolis</u> <u>1/10/57</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWARE</u> <u>Annapolis Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lanette</u>		22d. LOCATION (City, town, or county) (State) <u>Hillman</u> <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel A. Johnson</u>				ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 15 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. F. French</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. JONES</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>		4. DATE OF DEATH <i>Jan 15 1957</i>	
5. PLACE OF DEATH <i>Home</i>		6. CITY <i>Baltimore</i>		7. COUNTY <i>Harford</i>		8. STATE <i>Md.</i>	
9. OCCUPATION <i>Engineer</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>John J. Jones</i>	
13. SIGNATURE OF DECEASED <i>John J. Jones</i>		14. SIGNATURE OF WITNESS <i>John J. Jones</i>		15. SIGNATURE OF DECEASED <i>John J. Jones</i>		16. SIGNATURE OF WITNESS <i>John J. Jones</i>	
17. SIGNATURE OF DECEASED <i>John J. Jones</i>		18. SIGNATURE OF WITNESS <i>John J. Jones</i>		19. SIGNATURE OF DECEASED <i>John J. Jones</i>		20. SIGNATURE OF WITNESS <i>John J. Jones</i>	
21. SIGNATURE OF DECEASED <i>John J. Jones</i>		22. SIGNATURE OF WITNESS <i>John J. Jones</i>		23. SIGNATURE OF DECEASED <i>John J. Jones</i>		24. SIGNATURE OF WITNESS <i>John J. Jones</i>	
25. SIGNATURE OF DECEASED <i>John J. Jones</i>		26. SIGNATURE OF WITNESS <i>John J. Jones</i>		27. SIGNATURE OF DECEASED <i>John J. Jones</i>		28. SIGNATURE OF WITNESS <i>John J. Jones</i>	
29. SIGNATURE OF DECEASED <i>John J. Jones</i>		30. SIGNATURE OF WITNESS <i>John J. Jones</i>		31. SIGNATURE OF DECEASED <i>John J. Jones</i>		32. SIGNATURE OF WITNESS <i>John J. Jones</i>	
33. SIGNATURE OF DECEASED <i>John J. Jones</i>		34. SIGNATURE OF WITNESS <i>John J. Jones</i>		35. SIGNATURE OF DECEASED <i>John J. Jones</i>		36. SIGNATURE OF WITNESS <i>John J. Jones</i>	
37. SIGNATURE OF DECEASED <i>John J. Jones</i>		38. SIGNATURE OF WITNESS <i>John J. Jones</i>		39. SIGNATURE OF DECEASED <i>John J. Jones</i>		40. SIGNATURE OF WITNESS <i>John J. Jones</i>	
41. SIGNATURE OF DECEASED <i>John J. Jones</i>		42. SIGNATURE OF WITNESS <i>John J. Jones</i>		43. SIGNATURE OF DECEASED <i>John J. Jones</i>		44. SIGNATURE OF WITNESS <i>John J. Jones</i>	
45. SIGNATURE OF DECEASED <i>John J. Jones</i>		46. SIGNATURE OF WITNESS <i>John J. Jones</i>		47. SIGNATURE OF DECEASED <i>John J. Jones</i>		48. SIGNATURE OF WITNESS <i>John J. Jones</i>	
49. SIGNATURE OF DECEASED <i>John J. Jones</i>		50. SIGNATURE OF WITNESS <i>John J. Jones</i>		51. SIGNATURE OF DECEASED <i>John J. Jones</i>		52. SIGNATURE OF WITNESS <i>John J. Jones</i>	
53. SIGNATURE OF DECEASED <i>John J. Jones</i>		54. SIGNATURE OF WITNESS <i>John J. Jones</i>		55. SIGNATURE OF DECEASED <i>John J. Jones</i>		56. SIGNATURE OF WITNESS <i>John J. Jones</i>	
57. SIGNATURE OF DECEASED <i>John J. Jones</i>		58. SIGNATURE OF WITNESS <i>John J. Jones</i>		59. SIGNATURE OF DECEASED <i>John J. Jones</i>		60. SIGNATURE OF WITNESS <i>John J. Jones</i>	
61. SIGNATURE OF DECEASED <i>John J. Jones</i>		62. SIGNATURE OF WITNESS <i>John J. Jones</i>		63. SIGNATURE OF DECEASED <i>John J. Jones</i>		64. SIGNATURE OF WITNESS <i>John J. Jones</i>	
65. SIGNATURE OF DECEASED <i>John J. Jones</i>		66. SIGNATURE OF WITNESS <i>John J. Jones</i>		67. SIGNATURE OF DECEASED <i>John J. Jones</i>		68. SIGNATURE OF WITNESS <i>John J. Jones</i>	
69. SIGNATURE OF DECEASED <i>John J. Jones</i>		70. SIGNATURE OF WITNESS <i>John J. Jones</i>		71. SIGNATURE OF DECEASED <i>John J. Jones</i>		72. SIGNATURE OF WITNESS <i>John J. Jones</i>	
73. SIGNATURE OF DECEASED <i>John J. Jones</i>		74. SIGNATURE OF WITNESS <i>John J. Jones</i>		75. SIGNATURE OF DECEASED <i>John J. Jones</i>		76. SIGNATURE OF WITNESS <i>John J. Jones</i>	
77. SIGNATURE OF DECEASED <i>John J. Jones</i>		78. SIGNATURE OF WITNESS <i>John J. Jones</i>		79. SIGNATURE OF DECEASED <i>John J. Jones</i>		80. SIGNATURE OF WITNESS <i>John J. Jones</i>	
81. SIGNATURE OF DECEASED <i>John J. Jones</i>		82. SIGNATURE OF WITNESS <i>John J. Jones</i>		83. SIGNATURE OF DECEASED <i>John J. Jones</i>		84. SIGNATURE OF WITNESS <i>John J. Jones</i>	
85. SIGNATURE OF DECEASED <i>John J. Jones</i>		86. SIGNATURE OF WITNESS <i>John J. Jones</i>		87. SIGNATURE OF DECEASED <i>John J. Jones</i>		88. SIGNATURE OF WITNESS <i>John J. Jones</i>	
89. SIGNATURE OF DECEASED <i>John J. Jones</i>		90. SIGNATURE OF WITNESS <i>John J. Jones</i>		91. SIGNATURE OF DECEASED <i>John J. Jones</i>		92. SIGNATURE OF WITNESS <i>John J. Jones</i>	
93. SIGNATURE OF DECEASED <i>John J. Jones</i>		94. SIGNATURE OF WITNESS <i>John J. Jones</i>		95. SIGNATURE OF DECEASED <i>John J. Jones</i>		96. SIGNATURE OF WITNESS <i>John J. Jones</i>	
97. SIGNATURE OF DECEASED <i>John J. Jones</i>		98. SIGNATURE OF WITNESS <i>John J. Jones</i>		99. SIGNATURE OF DECEASED <i>John J. Jones</i>		100. SIGNATURE OF WITNESS <i>John J. Jones</i>	

RECEIVED
JAN 15 1957
BUREAU V. 1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00112

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A. Co.</u> MIDDLE		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVERLY BEACH</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAVERLY BEACH</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CADLE AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>EDWIN</u> Last <u>CORPREW</u>		4. DATE OF DEATH Month <u>1</u> Day <u>26</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-13-1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CIVIL SERVICE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>		13. FATHER'S NAME <u>"U. N. K."</u>	
14. MOTHER'S MAIDEN NAME <u>"U. N. K."</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW#1</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>MARY PEARL CORPREW #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Disease</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>G. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>G. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1/26/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-30-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>MD</u>
23. BURIAL DIRECTOR'S SIGNATURE <u>John M. Lyster + Sons</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

RECEIVED

JAN 30 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00113

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis,</u>			
c. LENGTH OF STAY IN 1b <u>1</u> days				d. STREET ADDRESS <u>190 Duke of Gloucester St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. Naval Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eleanore</u> <u>Ridout</u> <u>DASHIELL</u>				4. DATE OF DEATH Month Day Year <u>January</u> <u>17</u> <u>1957</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-1866</u>	9. AGE (In years last birthday) <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Wrems Ridout</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Beaman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>U.S.N.H. Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infarction, myocardium</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery insufficiency</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pyelonephritis, acute, right.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>1-16</u> , 19 <u>57</u> , to <u>1-17-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-17-57</u> , 19 <u>57</u> , and that death occurred at <u>1810</u> P.M., from the causes and on the date stated above. <u>6:10</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>1-18-57</u>							
ACTUAL SIGNATURE <u>Vincent P. Butler, Jr.</u> M.D. <u>1-18-57</u>							
PHYSICIAN'S NAME (Type) <u>V.P. Butler Jr LT MC USN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-21-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>US NAVAL ACADEMY CEM ANNAPOLIS MD</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SON ANNAPOLIS MD</u>				24a. REC'D BY REGISTRAR <u>1/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale c. LENGTH OF STAY IN 1b 6 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 104 111 Avenue		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Same b. COUNTY Same c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Same d. STREET ADDRESS Same e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence Wilbur Deardoff		4. DATE OF DEATH Month January Day 15th. Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/12/1903
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 53	IF UNDER 24 HRS. Hours 53 Min. 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Lt. Commander in the Coast Guard		10b. KIND OF BUSINESS OR INDUSTRY Dayton, Ohio	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Deardoff		14. MOTHER'S MAIDEN NAME Carrie McGrew	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes Army and Navy		16. SOCIAL SECURITY NO. 218 36 3007	
17. INFORMANT Mrs. Harriett Deardoff (wife).		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cirrhosis of the liver (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4 y.		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED January 16 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 18 Jan '57	
22c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard J. Singleton		24a. REC'D BY REGISTRAR Jan 18 1957	
ADDRESS Glen Burnie, Md.		24b. REGISTRAR'S SIGNATURE L. J. DeHoy	

RECEIVED
JAN 18 1957

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN lb <u>39 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>422 Crain Highway S.W.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel Peter Donnelly</u>				4. DATE OF DEATH Month Day Year <u>Jan. 31 19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 23, 1877</u>	9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman (ret)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>A.A.Co. Police</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. John F. Donnelly</u>		Address <u>508 Glenview Ave. Glen Burnie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>3 y.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>422.2 Myocardial insufficiency</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Nov. 1/20th. 1957</u> , 19 <u>55</u> , to <u>2/1/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/20th. 1957</u> , 19 <u>57</u> , and that death occurred at <u>7.45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glen Burnie, Md.</u> DATE SIGNED <u>1 Feb. 1957</u>							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. <u>Glen Burnie, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Seng, Jr. - Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 5 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Schlabach</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED JOHN J. JONES</p>		<p>2. SEX Male</p>		<p>3. AGE 68 yrs</p>	
<p>4. DATE OF DEATH FEB 5 1957</p>		<p>5. PLACE OF DEATH 225 E. JEFFERSON ST.</p>		<p>6. CITY, STATE, AND COUNTRY BALTIMORE, MD, U.S.A.</p>	
<p>7. OCCUPATION Retired</p>		<p>8. MARITAL STATUS Married</p>		<p>9. EDUCATION High School</p>	
<p>10. CAUSE OF DEATH Coronary Thrombosis</p>		<p>11. MANNER OF DEATH Natural</p>		<p>12. SIGNATURE OF PHYSICIAN J. J. Jones</p>	
<p>13. SIGNATURE OF DECEASED (None)</p>		<p>14. SIGNATURE OF WITNESSES J. J. Jones</p>		<p>15. SIGNATURE OF REGISTRAR J. J. Jones</p>	

BUREAU V. R.

FEB 5 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00116

106

1. PLACE OF DEATH a. COUNTY <i>A.A.C.O</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A.A.C.O</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <i>Conradsville</i>				c. LENGTH OF STAY IN 1b <i>3 wks</i>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X2 Edgewater, Maryland</i>				d. STREET ADDRESS <i>1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>63 Anne Arundel General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>JAMES. OWEN DOVE</i>				4. DATE OF DEATH Month Day Year <i>JAN 24 1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 3 1880</i>		9. AGE (In years last birthday) <i>76 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>		11. BIRTHPLACE (State or foreign country) <i>McKendree Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>JAMES I Dove</i>				14. MOTHER'S MAIDEN NAME <i>Laura E Sherbert</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Address <i>JAMES A DOVE Shadyside Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pericardial Peritonitis - (2) Fracture</i> <i>570.2</i> DUE TO <i>Small bowel (Post operation) 20 days</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Onset of small bowel mesenteric thrombosis</i> DUE TO <i>Onset of small bowel mesenteric thrombosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <i>20 days</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Jan 3 1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 3</i> , 1957, to <i>Jan 24</i> , 1957, that I last saw the deceased alive on <i>Jan 24</i> , 1957, and that death occurred at <i>3:55 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>E. L. Linhardt</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>Chesapeake Bk, Annapolis Md 1/24/57</i>			
PHYSICIAN'S NAME (Type) <i>E. L. Linhardt</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/26/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>MT ZION</i>		22d. LOCATION (City, town, or county) (State) <i>Cotuit Mass</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Bertrand Hardner, Salisbury Md</i>				24a. REC'D BY REGISTRAR DATE <i>1/29/57</i>		24b. REGISTRAR'S SIGNATURE <i>E. L. Linhardt</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00117

107

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General</u>				e. STREET ADDRESS <u>1221 Gloucester</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DOUGHLAS FOREST DUVAL</u>				4. DATE OF DEATH Month <u>1</u> - Day <u>16</u> - Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-4-1870</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Col. U.S.A. Ret.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Col. U.S.A. Ret.</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Edmund Peyton Duval</u>				14. MOTHER'S MAIDEN NAME <u>Marion Lee Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Walden L</u>		17. INFORMANT <u>Mrs Wm Randall Sayles</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Paralytic Ileus</u> <u>570.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforated Viscus</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-16-</u> , 19 <u>57</u> , to <u>1-16-</u> , 19 <u>57</u> ; that I last saw the deceased alive on <u>1-16-</u> , 19 <u>57</u> , and that death occurred at <u>3:10</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James R. Martin</u>				M.D. <u>6800 St. Annapolis, Md.</u> DATE SIGNED <u>1/18/57</u>			
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>				<u>ANNAPOLIS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Annis</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Sayles Sons</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>10/18/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF NEXT OF KIN</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL</p>	
<p>17. SIGNATURE OF CHURCH OFFICIAL</p>		<p>18. SIGNATURE OF FUNERAL HOME</p>	
<p>19. SIGNATURE OF CEMETERY OFFICIAL</p>		<p>20. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>21. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>22. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>23. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>24. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>25. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>26. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>27. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>28. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>29. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>30. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>31. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>32. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>33. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>34. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>35. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>36. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>37. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>38. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>39. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>40. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>41. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>42. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>43. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>44. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>45. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>46. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>47. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>48. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>49. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>50. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>51. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>52. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>53. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>54. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>55. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>56. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>57. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>58. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>59. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>60. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>61. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>62. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>63. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>64. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>65. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>66. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>67. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>68. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>69. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>70. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>71. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>72. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>73. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>74. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>75. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>76. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>77. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>78. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>79. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>80. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>81. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>82. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>83. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>84. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>85. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>86. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>87. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>88. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>89. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>90. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>91. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>92. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>93. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>94. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>95. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>96. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>97. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>98. SIGNATURE OF INTERMENT OFFICIAL</p>	
<p>99. SIGNATURE OF INTERMENT OFFICIAL</p>		<p>100. SIGNATURE OF INTERMENT OFFICIAL</p>	

BUREAU V. S.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 Film 6210 2-13-57 et

CERTIFICATE OF DEATH

00118

Reg. Dist. No.

2

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>C.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>23 Lee St.</u>				d. STREET ADDRESS <u>23 Lee St.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>Eades</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-25-1876</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel Eades</u>				14. MOTHER'S MAIDEN NAME <u> </u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u> </u>				Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Senility</u> DUE TO <u>794x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u>Jan 31, 1957</u> , that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>11:30</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>2/1/57</u> ACTUAL SIGNATURE <u>John C. Hedeween</u> M.D. PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-3-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Will Brewer Hill</u>	
22d. LOCATION (City, town, or county) <u>Annapolis</u>				22e. (State) <u>MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Teese</u>				ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u> </u>	
24b. REGISTRAR'S SIGNATURE <u>John J. French</u>							

FEB 4 1957

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be extended within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

00119

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Ind</u>		COUNTY <u>A.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bristol</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bristol</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>JAMES FRANCIS EVANS</u>				(Month) (Day) (Year) <u>JAN. 6 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 30, 1955</u>	9. AGE last birthday <u>1</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ernest Evans</u>				14. MOTHER'S MAIDEN NAME <u>MARY Wood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
491X IMMEDIATE CAUSE (A) <u>Broncho-pneumonia</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 6</u> , 1957, to <u>Jan 6</u> , 1957, that I last saw the deceased alive on <u>Jan 6</u> , 1957, and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Emil H. Wilson</u> M.D.				ADDRESS (Street, city, town, state) <u>Baltimore, Md</u>		DATE SIGNED <u>1-6-57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>1/10/57</u>		NAME OF CEMETERY OR CREMATORY <u>Mosses</u>		LOCATION (City, town, or county) (State) <u>Bristol</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Shakelle Dent</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Emil H. Wilson</u>		ADDRESS <u>Baltimore</u>	
DATE <u>JAN 15 1957</u>							

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BUREAU V. S.

JAN 16 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

142

CERTIFICATE OF DEATH

00120

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>A. A.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Ind</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bristol</i>	c. LENGTH OF STAY IN 1b <i>life</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>xp Bristol</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>McKinley</i> Last <i>EVANS</i>		4. DATE OF DEATH <i>June 24 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 19 5-5 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		11. BIRTHPLACE (State or foreign country) <i>Bristol A.A.</i>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <i>Thomas Evans</i>		14. MOTHER'S MAIDEN NAME <i>Mary Bray</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Arthur Evans</i> Address <i>Bristol</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Coronary Disease</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 minutes</i> <i>Week</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>24 Jan</i> , 19 <i>57</i> , to <i>24 Jan</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>24 Jan</i> , 19 <i>57</i> , and that death occurred at <i>4:25</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W B Jasser</i>		ADDRESS (Street, city or town, state) <i>Wiper Marlboro Md</i> DATE SIGNED <i>1-24-57</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>	22b. DATE THEREOF <i>1/27/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Moses</i>	22d. LOCATION (City, town, or county) (State) <i>Drury Ind</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Amie A. Johnson</i> ADDRESS <i>Annapolis</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 29 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Sha Belle Bentley</i>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00121
20

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Millersville</u>		c. LENGTH OF STAY IN 1b <u>14 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oakdale Circle</u>			d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Frank M. Fowler</u> First Middle Last			4. DATE OF DEATH <u>January 16th/ 1957</u> 19 Month Day Year		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/1887</u>		9. AGE (In years last birthday) <u>69</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator of a dump truck</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James H. Fowler</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Katherine, Fowler (Wife).</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/16/57</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/19/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE			24a. REC'D BY REGISTRAR DATE <u>21 1957</u>		
			24b. REGISTRAR'S SIGNATURE <u>K. M. Joyce</u>		

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES J. JONES		45		M		W		JAN 15 1912		NEW YORK	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
100 N. BOSTON ST.		CLOCK REPAIRER		HIGH SCHOOL		MARRIED		JAN 15 1935		NEW YORK	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF AUTOPSY		PLACE OF AUTOPSY	
JAN 21 1957		HOME		HEART DISEASE		NATURAL		JAN 21 1957		NEW YORK	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		SIGNATURE OF PHYSICIAN		TITLE OF PHYSICIAN		SIGNATURE OF CORONER		TITLE OF CORONER	
J. J. JONES		MEDICAL EXAMINER		J. J. JONES		PHYSICIAN		J. J. JONES		CORONER	

BUREAU V. 2

JAN 21 1957

RECEIVED

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00122

141 CERTIFICATE OF DEATH

Reg. Dist. No. 24

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Care Anne Arundel</u>		STATE <u>MD</u> COUNTY <u>ANNE ARUNDEL</u>		CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>SEVERN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SEVERN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>QUEENSTOWN ROAD</u>		STREET ADDRESS (If rural give location) <u>QUEENSTOWN ROAD</u>		LENGTH OF STAY (in this place) <u>YEARS</u>			
3. NAME OF DECEASED (Type or Print) <u>Samuel</u> (First) <u>Galloway</u> (Middle) <u></u> (Last)				4. DATE OF DEATH <u>Jan 31-57</u> (Month) (Day) (Year) <u>19</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWER</u>		8. DATE OF BIRTH <u>7/6/1896</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>FARMER</u>		9. AGE last birthday <u>60</u> yrs.		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. BIRTHPLACE (State or foreign country) <u>ANNE ARUNDEL Co MD</u>				12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>SAMUEL GALLOWAY</u>				14. MOTHER'S MAIDEN NAME <u>GRACE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>BERTHA JOHNSON SEVERN MD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>490X Lobar Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Cardiovascular Disease. Insult 10 years</u>	
19a. DATE OF OPERATION <u>4-22-57</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 4-57 to Jan 31-57, that I last saw the deceased alive on Jan 30-57, and that death occurred at 4:30 PM, from the causes and on the date stated above.							
SIGNATURE <u>Joseph H. Heston</u>				DATE SIGNED <u>1-31-57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				24. REC'D BY REGISTRAR <u>2/3/57</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>R. W. L. J. Sedby</u>				26. ADDRESS <u>St. Rest</u>			
27. REGISTRAR'S SIGNATURE <u>Harmon, MD</u>				28. ADDRESS			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Print or Write)

2. SEX (Print or Write) 3. AGE (Print or Write)

4. DATE OF DEATH (Print or Write)

5. PLACE OF DEATH (Print or Write)

6. CAUSE OF DEATH (Print or Write)

7. MANNER OF DEATH (Print or Write)

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF REGISTRAR

10. SIGNATURE OF WITNESS

11. SIGNATURE OF DECEASED (If Living)

12. SIGNATURE OF DECEASED (If Deceased)

13. SIGNATURE OF DECEASED (If Deceased)

14. SIGNATURE OF DECEASED (If Deceased)

15. SIGNATURE OF DECEASED (If Deceased)

BUREAU A. M.

FEB 5 1957

RECEIVED

MD 111-111111

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 14, Film G210 2-1-57 et
 145
 CERTIFICATE OF DEATH

00123

Reg. Dist. No. 24

1. PLACE OF DEATH o. COUNTY <u>A. A. County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X0 Ferndale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>21 Ferndale Avenue</u>				d. STREET ADDRESS <u>21 Ferndale Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E.</u> Last <u>Gill</u>				4. DATE OF DEATH Month <u>1</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11, 1883</u>		9. AGE (In years last birthday) yrs. <u>73</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman (Ret'd)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Department</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George E. Gill</u>				14. MOTHER'S MAIDEN NAME <u>Estelle M. Spurry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Miss Dorothy Gill, 21 Ferndale Ave., Ferndale</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis & failure</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 20</u> , 19 <u>57</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles B. MacDonald</u> M.D.				ADDRESS (Street, city or town, state) <u>P.O. Box 296</u>		DATE SIGNED <u>1-24-57</u>	
PHYSICIAN'S NAME (Type) <u>Eileen Burnie Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-28-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>Jan. 25, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Doolan</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. CAUSE OF DEATH</p>	
<p>9. MEDICAL HISTORY</p>		<p>10. DATE OF DEATH</p>	
<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF REGISTRAR</p>		<p>14. SIGNATURE OF WITNESSES</p>	

RECEIVED
BUREAU V. 4
 JAN 28 1957

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>			c. LENGTH OF STAY IN 1b <u>9 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>21 Ferndale Avenue</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Dorothea Henrietta Gill</u>				4. DATE OF DEATH Month Day Year <u>January 12th 19 57</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/5/86</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Frederick Keller</u>				14. MOTHER'S MAIDEN NAME <u>Dorothea Edell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Charles E. Gill (Husband) 21 Ferndale Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>General arteriosclerosis.</u> DUE TO (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>only today</u> , 19 <u>57</u> , to <u>1/12/57</u> , that I last saw the deceased alive on <u>1/12/57</u> , 19 <u>57</u> , and that death occurred at <u>4:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Glen Burnie, Md. 1/12/57</u>							
ACTUAL SIGNATURE <u>Gustave H. Faubert M.D.</u>		M.D. <u>Glen Burnie, Md.</u> <u>1/12/57</u>					
PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-16-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE <u>JAN 14 1957 L. J. DeAlba</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. SEX [Illegible]		3. AGE [Illegible]		4. RACE [Illegible]		5. DATE OF DEATH [Illegible]	
6. PLACE OF DEATH [Illegible]		7. CITY [Illegible]		8. COUNTY [Illegible]		9. STATE [Illegible]		10. ZIP CODE [Illegible]	
11. OCCUPATION [Illegible]		12. CAUSE OF DEATH [Illegible]		13. MANNER OF DEATH [Illegible]		14. MEDICAL HISTORY [Illegible]		15. OTHER INFORMATION [Illegible]	
16. SIGNATURE OF PHYSICIAN [Illegible]		17. SIGNATURE OF REGISTRAR [Illegible]		18. SIGNATURE OF WITNESS [Illegible]		19. SIGNATURE OF DECEASED [Illegible]		20. SIGNATURE OF NEXT OF KIN [Illegible]	

BUREAU V. S.

JAN 15 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00108

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>M.A.C.O</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>M.A.C.O</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.F.D #2-Box 243A-12</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis General Hospital</u>				d. STREET ADDRESS <u>Annapolis-MD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u>N.</u> Last <u>GOSNELL</u>				4. DATE OF DEATH Month <u>1</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 4, 1900</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Local Union</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Clarence W. Gosnell</u>				14. MOTHER'S MAIDEN NAME <u>Estelle Platt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-07-5338</u>		17. INFORMANT Address <u>Mrs. Vera K. Geldmacher 3533 W. Caton Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia disease</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>1-15-57</u>			
EXAMINER'S NAME (Type) <u>E. Linhardt-Annapolis-MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		22d. LOCATION (City, town, or county) (State) <u>Randalstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Burnside, Jr. 1900 Eutaw Place</u>				ADDRESS 		24a. REC'D BY REGISTRAR <u>Jan 17 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

110

CERTIFICATE OF DEATH

00125

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>63 Arundel General Hospital</u>		d. STREET ADDRESS <u>16 - Bennett Street</u>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>GREEN</u> Last <u>GREEN</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>24</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-19-1899</u> 37 yrs.
9. AGE (In years last birthday) <u>57</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OR WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Green</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Robinson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>24-05-069</u>	
17. INFORMANT <u>Anna Salonia Turner - Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage due rupture of</u> <u>156.1</u> DUE TO (b) <u>Esophageal Varices</u> DUE TO (c) <u>Carcinoma of the liver</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 15, 1956</u> to <u>Jan 24, 1957</u> , that I last saw the deceased alive on <u>Jan 24, 1957</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. L. Richardson</u>		DATE SIGNED <u>Feb 11, 1957</u>	
PHYSICIAN'S NAME (Type) <u>R. L. RICHARDSON M.D.</u>		M.D. <u>110 - 06 - 069</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-27-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beese, Jr.</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>1-29-57</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. Luchko</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *Charles Green*
2. SEX: *Male*
3. AGE: *3-11-1879*
4. OCCUPATION: *Compositor*
5. PLACE OF BIRTH: *St. Louis, Mo.*
6. DATE OF DEATH: *Jan 30 1907*
7. CAUSE OF DEATH: *Chronic disease*
8. PLACE OF DEATH: *St. Louis, Mo.*
9. SIGNATURE OF PHYSICIAN: *Wm. H. Green*
10. SIGNATURE OF WITNESSES: *Wm. H. Green*
11. SIGNATURE OF CORONER: *Wm. H. Green*
12. SIGNATURE OF DECEASED: *Wm. H. Green*

RECEIVED
JAN 30 1907
BUREAU V. A.

Charles Green
1-30-07
St. Louis, Mo.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00126

CERTIFICATE OF DEATH

Reg. Dist. No. 28

147

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u> ✓	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Crownsville</u>		LENGTH OF STAY (in this place) <u>5 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Crownsville State Hospital</u>				STREET ADDRESS (If rural give location) <u>22 X 02 R.F.D.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mary Ann Green</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 16 19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Not given</u>	9. AGE last birthday <u>79?</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Not given</u>				14. MOTHER'S MAIDEN NAME <u>Not given</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Crownsville Hospital</u> <u>Hospital Records Crownsville, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Uremia</u>							
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Pyelonephritis</u>							
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Dehydration - Arteriosclerosis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/12</u> , 19 <u>57</u> , to <u>1/16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/16</u> , 19 <u>57</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Loisell M. Henry Depp</u>				ADDRESS (Street, city, town, state) <u>M.D. Crownsville, Md.</u>		DATE SIGNED <u>1/17/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/26/57</u>		NAME OF CEMETERY OR CREMATORY <u>White Haven Cem.</u>		LOCATION (City, town, or county) (State) <u>White Haven Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>A. M. Joyce</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messersmith, Bivolar, Md.</u>		ADDRESS	
DATE <u>FEB 4 1957</u>							

CERTIFICATE OF DEATH

Reg. No. 100

AT THE RESIDENCE OF DECEASED

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Intermediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Place of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of Mayor

Signature of City Clerk

Signature of Town Clerk

Signature of Village Clerk

Signature of Ward Clerk

Signature of Precinct Clerk

Signature of Polling Place Clerk

Signature of Election Officer

Signature of County Auditor

Signature of State Auditor

Signature of U.S. Marshal

Signature of U.S. District Judge

Signature of U.S. Circuit Judge

Signature of U.S. Supreme Court Justice

Signature of U.S. Attorney General

Signature of U.S. Secretary of State

Signature of U.S. President

Signature of U.S. Vice President

Signature of U.S. Speaker of House

Signature of U.S. Senate President

Signature of U.S. Chief Justice

Signature of U.S. Associate Justice

Signature of U.S. District Judge

Signature of U.S. Circuit Judge

Signature of U.S. Supreme Court Justice

Signature of U.S. Attorney General

Signature of U.S. Secretary of State

Signature of U.S. President

Signature of U.S. Vice President

Signature of U.S. Speaker of House

Signature of U.S. Senate President

BUREAU V. 3

FEB 4 1957

RECEIVED

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Immediate Cause

Intermediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Place of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of Mayor

Signature of City Clerk

Signature of Town Clerk

Signature of Village Clerk

Signature of Ward Clerk

Signature of Precinct Clerk

Signature of Polling Place Clerk

Signature of Election Officer

Signature of County Auditor

Signature of State Auditor

Signature of U.S. Marshal

Signature of U.S. District Judge

Signature of U.S. Circuit Judge

Signature of U.S. Supreme Court Justice

Signature of U.S. Attorney General

Signature of U.S. Secretary of State

Signature of U.S. President

Signature of U.S. Vice President

Signature of U.S. Speaker of House

Signature of U.S. Senate President

Signature of U.S. Chief Justice

Signature of U.S. Associate Justice

Signature of U.S. District Judge

Signature of U.S. Circuit Judge

Signature of U.S. Supreme Court Justice

Signature of U.S. Attorney General

Signature of U.S. Secretary of State

Signature of U.S. President

Signature of U.S. Vice President

Signature of U.S. Speaker of House

Signature of U.S. Senate President

NOTED 1/27/57

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE OF MARYLAND. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, FOR A PERIOD OF FIFTY YEARS. IT IS TO BE MADE AVAILABLE TO ANY PERSON WHO REQUESTS IT, FOR A FEE OF FIVE CENTS. IT IS TO BE DESTROYED AFTER THE EXPIRATION OF THE FIFTY YEAR PERIOD.

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CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>X1 Davidsonville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>221 S. Cherry Grave Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETTA GLOVER GRIMES</u>				4. DATE OF DEATH Month Day Year <u>JANUARY 24 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1884</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jausha Glover</u>				14. MOTHER'S MAIDEN NAME <u>Mary Crandell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mr. Oscar Fay Grimes- Husband- same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary-Vascular Renal Disease</u> DUE TO (c) <u>Arteriosclerosis Generalized</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>4 yrs.</u> <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 10, 1949</u> to <u>Jan. 24, 1957</u> , that I last saw the deceased alive on <u>Jan. 24, 1957</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6 Shaw Street, Annapolis, Maryland</u> DATE SIGNED <u>1/25/57</u>							
ACTUAL SIGNATURE <u>James S. Martin</u> M.D.				PHYSICIAN'S NAME (Type) <u>James S. Martin MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>January 26, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davidsonville Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Davidsonville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>				24a. REC'D BY REGISTRAR DATE <u>1/25/57</u>			
ADDRESS <u>Annapolis, Md.</u>				24b. REGISTRAR'S SIGNATURE <u>V. D. D. D.</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

JAN 28 1957

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG210 1-29-57 et

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CERTIFICATE OF DEATH

00128

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Gate</u>				c. LENGTH OF STAY IN 1b <u>+2 East Gate.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. STREET ADDRESS <u>P. 1 Annapolis</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marion</u> Middle <u>Alice</u> Last <u>Harrod</u>				4. DATE OF DEATH Month <u>January</u> Day <u>18</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 1 1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Charleston S.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William C. Harrod</u>				14. MOTHER'S MAIDEN NAME <u>Harrod Ann Shaw</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Isabella Harrod P. 1 Annapolis</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1-12-57</u> to <u>1-17-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-17-57</u> , 19 <u>57</u> , and that death occurred at <u>10:22</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. J. Allen</u>				DATE SIGNED <u>1-23-57</u>			
PHYSICIAN'S NAME (Type) <u>A. J. ALLEN</u>				ADDRESS <u>Annapolis Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>✓</u>				22b. DATE THEREOF <u>✓</u>		22c. NAME OF CEMETERY OR CREMATORY	
22d. LOCATION (City, town, or county)				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ann H. Johnson</u>				ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR DATE <u>23 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mon. J. Lench</u>							

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 20 1957</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. SIGNATURE OF PHYSICIAN <i>Dr. Smith</i>	
10. SIGNATURE OF REGISTRAR <i>John Doe</i>		11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF WITNESS <i>John Doe</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>		21. SIGNATURE OF WITNESS <i>John Doe</i>	
22. SIGNATURE OF WITNESS <i>John Doe</i>		23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>		27. SIGNATURE OF WITNESS <i>John Doe</i>	
28. SIGNATURE OF WITNESS <i>John Doe</i>		29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>		33. SIGNATURE OF WITNESS <i>John Doe</i>	
34. SIGNATURE OF WITNESS <i>John Doe</i>		35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>		39. SIGNATURE OF WITNESS <i>John Doe</i>	
40. SIGNATURE OF WITNESS <i>John Doe</i>		41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>		45. SIGNATURE OF WITNESS <i>John Doe</i>	
46. SIGNATURE OF WITNESS <i>John Doe</i>		47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>		51. SIGNATURE OF WITNESS <i>John Doe</i>	
52. SIGNATURE OF WITNESS <i>John Doe</i>		53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>		57. SIGNATURE OF WITNESS <i>John Doe</i>	
58. SIGNATURE OF WITNESS <i>John Doe</i>		59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>		63. SIGNATURE OF WITNESS <i>John Doe</i>	
64. SIGNATURE OF WITNESS <i>John Doe</i>		65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>		69. SIGNATURE OF WITNESS <i>John Doe</i>	
70. SIGNATURE OF WITNESS <i>John Doe</i>		71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>		75. SIGNATURE OF WITNESS <i>John Doe</i>	
76. SIGNATURE OF WITNESS <i>John Doe</i>		77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>		81. SIGNATURE OF WITNESS <i>John Doe</i>	
82. SIGNATURE OF WITNESS <i>John Doe</i>		83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>		87. SIGNATURE OF WITNESS <i>John Doe</i>	
88. SIGNATURE OF WITNESS <i>John Doe</i>		89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>		93. SIGNATURE OF WITNESS <i>John Doe</i>	
94. SIGNATURE OF WITNESS <i>John Doe</i>		95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>		99. SIGNATURE OF WITNESS <i>John Doe</i>	
100. SIGNATURE OF WITNESS <i>John Doe</i>		101. SIGNATURE OF WITNESS <i>John Doe</i>		102. SIGNATURE OF WITNESS <i>John Doe</i>	

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JAN 23 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

00129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>a.a.</u> Co. <u>Maryland</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>a.a.c.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u> (<u>Bridge P.O.</u>) <u>Harrover, Pa.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>Peter</u> Last <u>Heil</u>		4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 12, 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman (Ret'd)</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>Philip Heil</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. ?</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>John L. Heil, 3218 Acton Road, Baltimore 14</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemiplegia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/4/57</u> , 19 <u>57</u> , to <u>1/6/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/6/57</u> , 19 <u>57</u> , and that death occurred at <u>11/57</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Manfred Shipley</u> , M.D.		DATE SIGNED <u>1/7/57</u>	
PHYSICIAN'S NAME (Type) <u>Frank E Shipley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-9-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Jessups, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc. 1217 St. Paul Street</u>		24a. REC'D BY REGISTRAR <u>JAN 9 1957</u>	
		24b. REGISTRAR'S SIGNATURE <u>Clara Hadley</u>	

150

+2

X

11. *Journal of the American Medical Association*, 277, 1996, 1025-1026.

21

1110

BUREAU V. S.

1957 9 JAN

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00130

150

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Dane</u> <u>Brundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>				d. STREET ADDRESS <u>Rockview Beach</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Daniel</u> Middle <u>Kent</u> Last <u>Ireland</u>				4. DATE OF DEATH Month <u>January</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 25, 1865</u>	
9. AGE (In years (last birthday) yrs. <u>91</u>)		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. Transit Co</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert County, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John F. Ireland</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>John F. Ireland, Rockview Beach, Pasadena, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>none</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>Several years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>0</u> p. m. <u>0</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Pasadena</u>				20g. (County) <u>Baltimore</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>December 1, 1953</u> to <u>January 7, 1957</u> , that I last saw the deceased alive on <u>January 7, 1957</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>				ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u>			
PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>				DATE SIGNED <u>Jan. 7, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc., 1217 St. Paul Street</u>				24a. REC'D BY REGISTRAR <u>JAN 9 1957</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Sealba</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		DATE OF DEATH	
HUSBAND		DATE OF BIRTH	
WIFE		DATE OF DEATH	
CHILD		DATE OF BIRTH	
SISTER		DATE OF BIRTH	
BROTHER		DATE OF BIRTH	
FATHER		DATE OF BIRTH	
MOTHER		DATE OF BIRTH	
PLACE OF BIRTH		DATE OF BIRTH	
PLACE OF DEATH		DATE OF DEATH	
CAUSE OF DEATH		DATE OF DEATH	
MANNER OF DEATH		DATE OF DEATH	
SIGNATURE OF DECEASED		DATE OF DEATH	
SIGNATURE OF WITNESS		DATE OF DEATH	
SIGNATURE OF PHYSICIAN		DATE OF DEATH	
SIGNATURE OF CLERK		DATE OF DEATH	
SIGNATURE OF JUDGE		DATE OF DEATH	
SIGNATURE OF SHERIFF		DATE OF DEATH	
SIGNATURE OF CORONER		DATE OF DEATH	
SIGNATURE OF JURY		DATE OF DEATH	
SIGNATURE OF COURT		DATE OF DEATH	
SIGNATURE OF STATE		DATE OF DEATH	
SIGNATURE OF NATION		DATE OF DEATH	
SIGNATURE OF WORLD		DATE OF DEATH	
SIGNATURE OF UNIVERSE		DATE OF DEATH	
SIGNATURE OF GOD		DATE OF DEATH	
SIGNATURE OF DEVIL		DATE OF DEATH	
SIGNATURE OF ANGEL		DATE OF DEATH	
SIGNATURE OF DEMON		DATE OF DEATH	
SIGNATURE OF SPIRIT		DATE OF DEATH	
SIGNATURE OF SOUL		DATE OF DEATH	
SIGNATURE OF BODY		DATE OF DEATH	
SIGNATURE OF MIND		DATE OF DEATH	
SIGNATURE OF HEART		DATE OF DEATH	
SIGNATURE OF LUNGS		DATE OF DEATH	
SIGNATURE OF LIVER		DATE OF DEATH	
SIGNATURE OF STOMACH		DATE OF DEATH	
SIGNATURE OF INTESTINES		DATE OF DEATH	
SIGNATURE OF BLADDER		DATE OF DEATH	
SIGNATURE OF UTERUS		DATE OF DEATH	
SIGNATURE OF VAGINA		DATE OF DEATH	
SIGNATURE OF PENIS		DATE OF DEATH	
SIGNATURE OF TESTES		DATE OF DEATH	
SIGNATURE OF OVARIES		DATE OF DEATH	
SIGNATURE OF SALIVARY GLANDS		DATE OF DEATH	
SIGNATURE OF PANCREAS		DATE OF DEATH	
SIGNATURE OF SPLEEN		DATE OF DEATH	
SIGNATURE OF THYROID GLAND		DATE OF DEATH	
SIGNATURE OF PARATHYROID GLANDS		DATE OF DEATH	
SIGNATURE OF ADRENAL GLANDS		DATE OF DEATH	
SIGNATURE OF PITUITARY GLAND		DATE OF DEATH	
SIGNATURE OF HYPOTHALAMUS		DATE OF DEATH	
SIGNATURE OF HYPOTHALAMIC GLAND		DATE OF DEATH	
SIGNATURE OF PINEAL GLAND		DATE OF DEATH	
SIGNATURE OF EPITHELIUM		DATE OF DEATH	
SIGNATURE OF CONNECTIVE TISSUE		DATE OF DEATH	
SIGNATURE OF MUSCLES		DATE OF DEATH	
SIGNATURE OF BONES		DATE OF DEATH	
SIGNATURE OF SKIN		DATE OF DEATH	
SIGNATURE OF HAIR		DATE OF DEATH	
SIGNATURE OF NAILS		DATE OF DEATH	
SIGNATURE OF TEETH		DATE OF DEATH	
SIGNATURE OF EYES		DATE OF DEATH	
SIGNATURE OF EARS		DATE OF DEATH	
SIGNATURE OF NOSE		DATE OF DEATH	
SIGNATURE OF MOUTH		DATE OF DEATH	
SIGNATURE OF PHARYNX		DATE OF DEATH	
SIGNATURE OF LARYNX		DATE OF DEATH	
SIGNATURE OF TRACHEA		DATE OF DEATH	
SIGNATURE OF BRONCHI		DATE OF DEATH	
SIGNATURE OF LUNGS		DATE OF DEATH	
SIGNATURE OF HEART		DATE OF DEATH	
SIGNATURE OF BLOOD VESSELS		DATE OF DEATH	
SIGNATURE OF LYMPHATIC SYSTEM		DATE OF DEATH	
SIGNATURE OF IMMUNE SYSTEM		DATE OF DEATH	
SIGNATURE OF NERVOUS SYSTEM		DATE OF DEATH	
SIGNATURE OF ENDOCRINE SYSTEM		DATE OF DEATH	
SIGNATURE OF REPRODUCTIVE SYSTEM		DATE OF DEATH	
SIGNATURE OF DIGESTIVE SYSTEM		DATE OF DEATH	
SIGNATURE OF RESPIRATORY SYSTEM		DATE OF DEATH	
SIGNATURE OF CIRCULATORY SYSTEM		DATE OF DEATH	
SIGNATURE OF EXCRETORY SYSTEM		DATE OF DEATH	
SIGNATURE OF INTEGUMENTARY SYSTEM		DATE OF DEATH	
SIGNATURE OF SKELETAL SYSTEM		DATE OF DEATH	
SIGNATURE OF MUSCULOSKELETAL SYSTEM		DATE OF DEATH	
SIGNATURE OF ENTIRE BODY		DATE OF DEATH	

BUREAU V. 3

JAN 9 1957

RECEIVED

BUREAU V. 8

JAN 18 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00132

152

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Allen Burnie</i>		c. LENGTH OF STAY IN 1b <i>5 mo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>132 Carroll Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>BLANCHE</i> Middle <i>L</i> Last <i>JOHNSON</i>		4. DATE OF DEATH Month <i>JAN</i> Day <i>4</i> Year <i>1957</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 27, 1880</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework (ret.)</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
10. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
12. FATHER'S NAME <i>Charles B. Long</i>		13. MOTHER'S MAIDEN NAME <i>Mary A. Giese</i>	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		15. SOCIAL SECURITY NO. <i>none</i>	
16. INFORMANT <i>Mrs Anna Marie</i>		17. Address <i>Same as #1</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute pulmonary congestion</i> DUE TO <i>381X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral vascular accident</i> DUE TO (c) <i>arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>3 days</i> <i>10 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>bilateral cataracts, aortic regurgitation</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>no</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <i>X</i> <i>19</i>		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>no</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4 December, 1956</i> , to <i>4 Jan</i> , 1957, that I last saw the deceased alive on <i>4 Jan</i> , 1957, and that death occurred at <i>3:45 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Hubert F. Manuzak</i>		DATE SIGNED <i>4 Jan 57</i>	
PHYSICIAN'S NAME (Type) <i>HUBERT F. MANUZAK</i>		<i>GLEN BURNIE, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 7, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Mem. Ph.</i>		22d. LOCATION (City, town, or county) (State) <i>Howard Co., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. J. Singlet</i>		24a. REC'D BY REGISTRAR DATE <i>Jan 7, 1957</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>L. J. DeAlba</i>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00133

153

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Boonsboro			
c. LENGTH OF STAY IN 1b 14 days				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Lakin Avenue			
3. NAME OF DECEASED (Type or print) First Jennie Middle Johnson Last Johnson				4. DATE OF DEATH Month 1 Day 3 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not listed	
9. AGE (In years last birthday) 81?		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.				10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Unk.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Unk.				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Crownsville State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Hypertensive Cardiovascular - Renal Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Hypostatic Pnumonia and Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pnumonia and Senility				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 12/20 , 19 56 , to 1/3 , 19 57 , that I last saw the deceased alive on 1/3 , 19 57 , and that death occurred at 7:20 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville, Md.			
DATE SIGNED 1/4/57							
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JANUARY-12-1957		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Isabel H. H. H.				ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR JAN 14 1957	
				24b. REGISTRAR'S SIGNATURE E. M. Joyce			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
154
CERTIFICATE OF DEATH

00134
28

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN b. 1 yr. 3 mos. 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 556 W. Lanvale Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Rebecca Middle Owens Last Johnson				4. DATE OF DEATH Month 1 Day 8 Year 1957			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/5/79	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME #A000000 Squire Johnson				14. MOTHER'S MAIDEN NAME #A000000 Margaret Foster			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Penumonia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular Disease 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/14 , 19 56 , to 1/8 , 19 57 , that I last saw the deceased alive on 1/8 , 19 57 , and that death occurred at 9:30 a. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 1/9/57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/57		22c. NAME OF CEMETERY OR CREMATORY Magothy Cemetery		22d. LOCATION (City, town, or county) (State) Magothy A.A. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Kate R. Williams				ADDRESS Schraeder St		24a. REC'D BY REGISTRAR AN 11 1957	
				24b. REGISTRAR'S SIGNATURE J. M. Joyce			

JAN 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00135

112

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>909 Wells Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>(Mike) GEORGE S. JONES</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>30</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 3, 1889</u>
9. AGE (In years lost birthday) <u>68</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Labor Forman</u>	11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.GOV.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Jones</u>		14. MOTHER'S MAIDEN NAME <u>Mary Holland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Stella Marie Jones- Wife- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary vascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>162X Bronchogenic carcinoma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>56</u> to <u>Jan. 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 28</u> , 19 <u>57</u> , and that death occurred at <u>4:15</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>2/1/57</u>			
ACTUAL SIGNATURE <u>John H. Hedeman</u> M.D.		PHYSICIAN'S NAME (Type) <u>John Hedeman MD</u> <u>90 Cathedral Street, Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-2-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ben H. Hopping</u> HOPPING FUNERAL HOME		24. REC'D BY REGISTRAR DATE <u>FEB 4 1957</u>	
ADDRESS <u>Annapolis, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

113

CERTIFICATE OF DEATH

0013621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A. Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x27 Mayo</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Laverne Marie Jones</i>		4. DATE OF DEATH Month Day Year <i>1 10 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-11-56</i>
9. AGE (In years last birthday) yrs. <i>6</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Amos Jones Jr.</i>		14. MOTHER'S MAIDEN NAME <i>Mable Stewart</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no. or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Amos Jones - Mayo, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>493x</i> DUE TO <i>Pneumonia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <i>1-2-57</i> , 19____, to <i>1-10-57</i> , 19____, that I last saw the deceased alive on <i>1-10-57</i> , 19____, and that death occurred at <i>6:30</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>62 Cathedral St Annapolis Md</i> DATE SIGNED <i>1-11-57</i> ACTUAL SIGNATURE <i>H. Allen</i> M.D. NAME (Type) <i>A. T. ALLEN</i> 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> 22b. DATE THEREOF <i>1-12-57</i> 22c. NAME OF CEMETERY OR CREMATORY <i>St Mark</i> 22d. LOCATION (City, town, or county) (State) <i>Mayo Md</i> 23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II - Annapolis, Md</i> ADDRESS 24a. REC'D BY REGISTRAR <i>Jan. J. French</i> 24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00137

155 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH COUNTY <u>ANNE-ARUNDEL</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harmans</u> LENGTH OF STAY (in, this place) <u>Life</u> TOWN <u>Harmans</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dorsey Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Anne-Arundel</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harmans</u> TOWN <u>Harmans</u> STREET ADDRESS (If rural, give location) <u>Dorsey Road</u>	
3. NAME OF DECEASED (Type or Print) <u>J</u> (First) <u>HARPER</u> (Middle) <u>KELBAUGH</u> (Last)		4. DATE OF DEATH <u>Jan.</u> <u>27</u> <u>1957</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Dec. 20 - 1911</u> 9. AGE last birthday <u>45</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Developer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>	11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Emory Kelbaugh</u>	
14. MOTHER'S MAIDEN NAME <u>Olga Black</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If year, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY No. <u>Unknown</u>		17. INFORMANT AND ADDRESS <u>114 Dinsdale Ave. Mrs. Elizabeth Farthing - Ferndale Md.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>MYOCARDIAL INFARCTION</u>		<u>HYPERTENSION</u> <u>GENERALIZED ARTERIOSCLEROSIS</u>	<u>1 MO</u>
Antecedent cause(s) (b) <u>HYPERTENSION</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>GENERALIZED ARTERIOSCLEROSIS</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
SUICIDE HOMICIDE	INJURY		
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 27 Dec., 1956, to 2 JAN., 1957, that I last saw the deceased alive on 20 JAN., 1957, and that death occurred at 8:00 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) George E. Groleau MD ADDRESS Elmhurst 27, md DATE SIGNED 28 JAN. 57

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Jan. 30 - 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Friendship Cemetery</u>	LOCATION (City, town, or county) <u>Ft. Meade Rd. A.Aco. Md.</u> (State)
DATE REC'D BY LOCAL REG. <u>Jan 29 1957</u>	REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>	24. FUNERAL DIRECTOR <u>R. V. Singleton</u>	ADDRESS <u>Glen Burnie, Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 31 1957

BUREAU V. S.

156 CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				c. LENGTH OF STAY IN 1b 40 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Keys Last Keys				4. DATE OF DEATH Month Jan Day 26 Year 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unknown	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day worker				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs Rena J. Brown 1007 Bently Street, Balt., Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Hypertensive Cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Vascular accident INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 24 19 57 , to Jan 26 19 57 , that I last saw the deceased alive on Jan 25 19 57 , and that death occurred at 2 05 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Conwell Newton M.D. Crownsville State Hospital 1-26-57							
ACTUAL SIGNATURE Conwell Newton M.D. Crownsville State Hospital 1-26-57							
PHYSICIAN'S NAME (Type) Conwell Newton Crownsville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		1-29-57		Brooks Chapel		Calvert County, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice				ADDRESS 6614 Barred		24a. REC'D BY REGISTRAR DATE 1-30-57	
						24b. REGISTRAR'S SIGNATURE A. M. J. J. J.	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

JAN 31 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

ITEMS 8 9 15: 0-10 2-1-57
Item 18 Film 211 3-8-57

CERTIFICATE OF DEATH

Reg. Dist. No.

00139

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Massachusetts</u> b. COUNTY <u>Barnstable</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>2 hrs 16 min</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U. S. Army Hospital</u>				d. STREET ADDRESS <u>West Barnstable 58 x - 3</u>			
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>ELIZABETH</u> Last <u>LACOURCIERE</u>				4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1919</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mary Clewes</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Husband, 1662 Waverly Way, Baltimore 12, Maryland</u>		18. CAUSE OF DEATH [Enter one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(1) Inevitable abortion (2) acute endometritis</u> DUE TO <u>651.3</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(3) generalized capillary congestion (history of cardiac arrhythmia with profound shock)</u> DUE TO (c) <u>(4) acute pulmonary congestion and (5) edema.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. f. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 28</u> , 19 <u>57</u> , to <u>Jan 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 28</u> , 19 <u>57</u> , and that death occurred at <u>1316 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Murray K Mantoath</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>USAH, Fort George G. Meade, Md. 28 Jan 57</u>			
PHYSICIAN'S NAME (Type) <u>MURRAY K. MANTOOTH, CAPT, MC, USAH, Fort George G. Meade, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hyannis, Mass</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, St Paul & Preston St Baltimore</u>				24a. REC'D BY REGISTRAR <u>W. L. Saylor</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Saylor</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 31 1957

RECEIVED

1557-1328
1919-1018

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00140

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 21

158

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X 2 Edgewater	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Edgewater, Maryland		d. STREET ADDRESS Edgewater, Md.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MABEL Middle L Last LARRIMORE		4. DATE OF DEATH Month JANUARY Day 14, Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1885
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own Home	11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Smith	
14. MOTHER'S MAIDEN NAME Kate/ (Unknown)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT William D. Larrimore- Husband- same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) 4444X DUE TO cause lost, (c)			INTERVAL BETWEEN ONSET AND DEATH Asudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 6:30 9:00 1-14- 19 57	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Edgewater, Anne Arundel, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Elmer G. Linhardt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Elmer G. Linhardt		DATE SIGNED January 15, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 17, 57	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Cemet.	22d. LOCATION (City, town, or county) (State) Annapolis, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home		24a. REC'D BY REGISTRAR JAN 18 1957	
ADDRESS Annapolis, Md.		24b. REGISTRAR'S SIGNATURE Wm. J. French	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

WYOMING STATE DEPARTMENT OF HEALTH - BATHING 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

JAN 18 1957

RECEIVED

159

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gibson Island</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X26 Gibson Island</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Paisley Rd., Gibson Island</u>				d. STREET ADDRESS <u>Paisley Rd., Gibson Island</u>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Bell</u> Last <u>Lee</u>				4. DATE OF DEATH Month <u>January</u> Day <u>4</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 16, 1883</u>	
9. AGE (In years last birthday) yrs. <u>73</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u> Hours <u>1</u> Min. <u>0</u>		IF UNDER 24 HRS. Hours <u>1</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>North Carolina</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Marshall MacDonald</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Ann Crook</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Daughter - M. Elizabeth Lee, Gibson Island, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pulmonary edema</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>1 1/2 hrs.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>January 4, 1957</u> , to <u>January 4, 1957</u> , that I last saw the deceased alive on <u>January 4, 1957</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kathleen H. Lyons</u> M.D.				ADDRESS (Street, city or town, state) <u>Paisley Rd., Gibson Island, Md.</u>			
DATE SIGNED <u>1/4/57</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>1/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cross Creek Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Fayetteville, N. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. J. Lickner & Sons - Balto 17, Md</u>				ADDRESS <u>Balto 17, Md</u>		24a. REC'D BY REGISTRAR DATE <u>1/8/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. Deall</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

RECEIVED
JAN 9 1957
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

114

CERTIFICATE OF DEATH

Reg. Dist. No.

00142

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x2 Shady Side</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>		d. STREET ADDRESS <i>Lerch Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>James Albert Leek</i>		4. DATE OF DEATH Month Day Year <i>January 21 1957</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>15 October 1901</i>
9. AGE (In years last birthday) <i>55</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Printer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Publishing</i>	
11. BIRTHPLACE (State or foreign country) <i>Knoxville, Tennessee</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Cal C Leek</i>		14. MOTHER'S MAIDEN NAME <i>Minnie V. Nighbert</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT Address <i>Alma Neff Leek-Wife</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary Occlusion acute</i> DUE TO <i>one hour</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ventricular fibrillation (Clinical)</i> <i>one hour</i> DUE TO <i>Old myocardial infarction</i> <i>?</i> (c) <i>Generalized atherosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Generalized atherosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July</i> , 19 <i>55</i> , to <i>January</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>21 January</i> , 19 <i>57</i> , and that death occurred at <i>1:00 P.</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Franklin D Hendricks</i> M.D.		ADDRESS (Street, city or town, state) <i>Shady Side</i>	
DATE SIGNED <i>January 24 1957</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-24-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>North Lincoln</i>		22d. LOCATION (City, town, or county) (State) <i>Bladenburg Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. W. Henderson</i>		ADDRESS <i>Wash. D. C.</i>	
24a. REC'D BY REGISTRAR <i>DATE</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. J. Funcher</i>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. ROY</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>JAN 24 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>HOME</i>	
7. CAUSE OF DEATH <i>HEART DISEASE</i>		8. MANNER OF DEATH <i>NATURAL</i>		9. PLACE OF BIRTH <i>NEW YORK</i>	
10. OCCUPATION <i>SALES</i>		11. MARITAL STATUS <i>MARRIED</i>		12. EDUCATION <i>HIGH SCHOOL</i>	
13. PREVIOUS ILLNESS <i>ANGINA PECTORIS</i>		14. MEDICAL HISTORY <i>NO</i>		15. SURVIVAL <i>NO</i>	
16. SIGNATURE OF DECEASED <i>[Signature]</i>		17. SIGNATURE OF WITNESS <i>[Signature]</i>		18. SIGNATURE OF DECEASED <i>[Signature]</i>	
19. SIGNATURE OF DECEASED <i>[Signature]</i>		20. SIGNATURE OF WITNESS <i>[Signature]</i>		21. SIGNATURE OF DECEASED <i>[Signature]</i>	
22. SIGNATURE OF DECEASED <i>[Signature]</i>		23. SIGNATURE OF WITNESS <i>[Signature]</i>		24. SIGNATURE OF DECEASED <i>[Signature]</i>	
25. SIGNATURE OF DECEASED <i>[Signature]</i>		26. SIGNATURE OF WITNESS <i>[Signature]</i>		27. SIGNATURE OF DECEASED <i>[Signature]</i>	
28. SIGNATURE OF DECEASED <i>[Signature]</i>		29. SIGNATURE OF WITNESS <i>[Signature]</i>		30. SIGNATURE OF DECEASED <i>[Signature]</i>	
31. SIGNATURE OF DECEASED <i>[Signature]</i>		32. SIGNATURE OF WITNESS <i>[Signature]</i>		33. SIGNATURE OF DECEASED <i>[Signature]</i>	
34. SIGNATURE OF DECEASED <i>[Signature]</i>		35. SIGNATURE OF WITNESS <i>[Signature]</i>		36. SIGNATURE OF DECEASED <i>[Signature]</i>	
37. SIGNATURE OF DECEASED <i>[Signature]</i>		38. SIGNATURE OF WITNESS <i>[Signature]</i>		39. SIGNATURE OF DECEASED <i>[Signature]</i>	
40. SIGNATURE OF DECEASED <i>[Signature]</i>		41. SIGNATURE OF WITNESS <i>[Signature]</i>		42. SIGNATURE OF DECEASED <i>[Signature]</i>	
43. SIGNATURE OF DECEASED <i>[Signature]</i>		44. SIGNATURE OF WITNESS <i>[Signature]</i>		45. SIGNATURE OF DECEASED <i>[Signature]</i>	
46. SIGNATURE OF DECEASED <i>[Signature]</i>		47. SIGNATURE OF WITNESS <i>[Signature]</i>		48. SIGNATURE OF DECEASED <i>[Signature]</i>	
49. SIGNATURE OF DECEASED <i>[Signature]</i>		50. SIGNATURE OF WITNESS <i>[Signature]</i>		51. SIGNATURE OF DECEASED <i>[Signature]</i>	
52. SIGNATURE OF DECEASED <i>[Signature]</i>		53. SIGNATURE OF WITNESS <i>[Signature]</i>		54. SIGNATURE OF DECEASED <i>[Signature]</i>	
55. SIGNATURE OF DECEASED <i>[Signature]</i>		56. SIGNATURE OF WITNESS <i>[Signature]</i>		57. SIGNATURE OF DECEASED <i>[Signature]</i>	
58. SIGNATURE OF DECEASED <i>[Signature]</i>		59. SIGNATURE OF WITNESS <i>[Signature]</i>		60. SIGNATURE OF DECEASED <i>[Signature]</i>	
61. SIGNATURE OF DECEASED <i>[Signature]</i>		62. SIGNATURE OF WITNESS <i>[Signature]</i>		63. SIGNATURE OF DECEASED <i>[Signature]</i>	
64. SIGNATURE OF DECEASED <i>[Signature]</i>		65. SIGNATURE OF WITNESS <i>[Signature]</i>		66. SIGNATURE OF DECEASED <i>[Signature]</i>	
67. SIGNATURE OF DECEASED <i>[Signature]</i>		68. SIGNATURE OF WITNESS <i>[Signature]</i>		69. SIGNATURE OF DECEASED <i>[Signature]</i>	
70. SIGNATURE OF DECEASED <i>[Signature]</i>		71. SIGNATURE OF WITNESS <i>[Signature]</i>		72. SIGNATURE OF DECEASED <i>[Signature]</i>	
73. SIGNATURE OF DECEASED <i>[Signature]</i>		74. SIGNATURE OF WITNESS <i>[Signature]</i>		75. SIGNATURE OF DECEASED <i>[Signature]</i>	
76. SIGNATURE OF DECEASED <i>[Signature]</i>		77. SIGNATURE OF WITNESS <i>[Signature]</i>		78. SIGNATURE OF DECEASED <i>[Signature]</i>	
79. SIGNATURE OF DECEASED <i>[Signature]</i>		80. SIGNATURE OF WITNESS <i>[Signature]</i>		81. SIGNATURE OF DECEASED <i>[Signature]</i>	
82. SIGNATURE OF DECEASED <i>[Signature]</i>		83. SIGNATURE OF WITNESS <i>[Signature]</i>		84. SIGNATURE OF DECEASED <i>[Signature]</i>	
85. SIGNATURE OF DECEASED <i>[Signature]</i>		86. SIGNATURE OF WITNESS <i>[Signature]</i>		87. SIGNATURE OF DECEASED <i>[Signature]</i>	
88. SIGNATURE OF DECEASED <i>[Signature]</i>		89. SIGNATURE OF WITNESS <i>[Signature]</i>		90. SIGNATURE OF DECEASED <i>[Signature]</i>	
91. SIGNATURE OF DECEASED <i>[Signature]</i>		92. SIGNATURE OF WITNESS <i>[Signature]</i>		93. SIGNATURE OF DECEASED <i>[Signature]</i>	
94. SIGNATURE OF DECEASED <i>[Signature]</i>		95. SIGNATURE OF WITNESS <i>[Signature]</i>		96. SIGNATURE OF DECEASED <i>[Signature]</i>	
97. SIGNATURE OF DECEASED <i>[Signature]</i>		98. SIGNATURE OF WITNESS <i>[Signature]</i>		99. SIGNATURE OF DECEASED <i>[Signature]</i>	
100. SIGNATURE OF DECEASED <i>[Signature]</i>		101. SIGNATURE OF WITNESS <i>[Signature]</i>		102. SIGNATURE OF DECEASED <i>[Signature]</i>	

BUREAU V. S.

JAN 24 1957

RECEIVED

1-24-57

115 CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 24

1. PLACE OF DEATH- COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Anne Arundel	
CITY (If outside corporate limits, write RURAL and give nearest town) Rural		CITY (If outside corporate limits, write RURAL and give nearest town) Rural: Annapolis, Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital Annapolis, Maryland		STREET ADDRESS (If rural, give location) Defence Highway Gaithersburg Md	
3. NAME OF DECEASED (Type or Print)	(First) Louis (Middle)	(Last) LEGG	4. DATE OF DEATH (Month) 1 (Day) 3 (Year) 1957
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH ??
9. AGE last birthday 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME ??		14. MOTHER'S MAIDEN NAME ??	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY No. 234-16-2123	
17. INFORMANT AND ADDRESS Goldie Wasson			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
42.2.1 Immediate cause (a) arteriosclerosis secondary			
Antecedent cause(s) (b) Chronic hypertension			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Dead on arrival at hospital in ambulance			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE [Signature]		DATE SIGNED [Signature]	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Jan 5-1957	
NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		LOCATION (City, town, or county) (State) Brooklyn Ga Co Md	
DATE REC'D BY LOCAL REG Jan 7, 1957		24. FUNERAL DIRECTOR Demard G Frink	
REGISTRAR'S SIGNATURE L. J. Dea...		ADDRESS Elly Brum...	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 9 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116

CERTIFICATE OF DEATH

00144

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>63 Anne Arundel Gen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Linthicum</u>				4. DATE OF DEATH Month Day Year <u>Jan. 22 1957</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 23, 1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Annapolis</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Theodore Hodgkin Linthicum</u>				14. MOTHER'S MAIDEN NAME <u>Georgeanna Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT <u>Sister</u> Address <u>Same</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 450.0 DUE TO <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>54</u> , to <u>Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-22-57</u> , 19 <u>57</u> , and that death occurred at <u>5:30</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park md</u> DATE SIGNED <u>1-22-57</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u>				<u>Severna Park md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-23-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis md</u>				24a. REC'D BY REGISTRAR <u>1/21/57</u>		24b. REGISTRAR'S SIGNATURE <u>J. O. Smith</u>	

RECEIVED
JAN 23 1957
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

117

CERTIFICATE OF DEATH

00145

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1243 Tyler Ave</u>		d. STREET ADDRESS <u>1 1243 Tyler Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Raymond George Lorenzen</u>		4. DATE OF DEATH <u>January 3 1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3 1909</u>
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Diesel Motors</u>	
11. BIRTHPLACE (State or foreign country) <u>North Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James T. Lorenzen</u>		14. MOTHER'S MAIDEN NAME <u>Margaret McCory</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1930-34</u>		16. SOCIAL SECURITY NO. <u>1930-34</u>	
17. INFORMANT <u>Doris V. Lorenzen</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pulmonary tuberculosis</u> <u>002X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 18</u> , 19 <u>46</u> , to <u>Jan. 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec. 28</u> , 19 <u>57</u> , and that death occurred at <u>8:35 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>31 Smithgate Dr., Annapolis, Md.</u>	
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		DATE SIGNED <u>1/4/57</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 5, 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>U. Brown</u>	
24b. REGISTRAR'S SIGNATURE		DATE	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

BUREAU V. S.

JAN 10 1957

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MARYLAND STATE DEPARTMENT OF HEALTH

00146

118 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Dorsey</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>B.A.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Rt 1 Route 5 River Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Howard</u> (Middle) <u>Stanley</u> (Last) <u>Loring</u>	4. DATE OF DEATH <u>Jan 21</u> 19 <u>57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 4 1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>	9. AGE last birthday <u>63</u> yrs. If under 1 year Months Days If under 24 hrs. Min.
11. FATHER'S NAME <u>Chas A Loring</u>		12. CITIZEN OF WHAT COUNTRY? <u>MD</u>	
13. MOTHER'S MAIDEN NAME <u>Dovie Wright</u>		14. INFORMANT AND ADDRESS <u>Catharine Loring River Rd Annapolis MD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <u>Acute coronary thrombosis</u>		<u>1/2 hour</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Coronary insufficiency</u>		<u>3 years</u>
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <u>R. M. McLaughlin</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Pasadena, Md.</u>	DATE SIGNED <u>Jan. 22, 1957</u>
23. FUNERAL, CREMATION OR BURIAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan 25 1957</u>	NAME OF CEMETERY OR CREMATORY <u>Bellview</u>	LOCATION (City, town, or county) (State) <u>Bethesda</u>
DATE REC'D BY LOCAL REG. <u>1/24/57</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Wells Funeral Home</u>	ADDRESS <u>4210 Belair Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JAN 28 1957
BUREAU V. S.

Reg. Dist. No. **00147**

1601 Items 1, 9 FilmG211 2-25-57 et

1. PLACE OF DEATH a. COUNTY <u>D.C.</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Wash</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sibley in Bay</u>		c. LENGTH OF STAY IN TB <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wash D.C.</u> <u>02X2-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>General Hospital</u>				d. STREET ADDRESS <u>5329 Ill. Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Edward Joseph Lynch</u>		First Middle Last		4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1957</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2-2-1895</u>		9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Buckeye</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Michael P Lynch</u>		14. MOTHER'S MAIDEN NAME <u>Mary E by C Rosemary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>011-44-3471</u>		17. INFORMANT <u>Dr Wm M. J. Lynch - physician</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Lesion</u> (c) <u>Stroke</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Washington D.C.</u>	
20f. (City or town) <u>Washington</u>		(County) <u>D.C.</u>		(State) <u>D.C.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>E. Linhardt</u>		EXAMINER'S NAME (Type) <u>E. Linhardt</u>		DATE SIGNED <u>1/22/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>1-26-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEM.</u>	
22d. LOCATION (City, town, or county) <u>WASHINGTON</u>		(State) <u>D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>N. J. ...</u>		ADDRESS <u>2732 N. ...</u>		24a. REC'D BY REGISTRAR DATE <u>1/23/57</u>	
24b. REGISTRAR'S SIGNATURE <u>J. ...</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00148

161

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena				c. LENGTH OF STAY IN 1b 15 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pasadena Rd. Rte.9, Box 52				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pasadena Rd. Rte.9, Box 52				d. STREET ADDRESS Pasadena Rd., Rte9, Box 52			
3. NAME OF DECEASED (Type or print) First William James Majerowicz Middle (Myers) Last 4. DATE OF DEATH Month Jan. Day 3 Year 1957				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 8, 1896	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 60 Hours 60 Min.		IF UNDER 24 HRS. Months 60 Days 60 Hours 60 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician				10b. KIND OF BUSINESS OR INDUSTRY Md. Drydock		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Valentine Majerowicz				14. MOTHER'S MAIDEN NAME Josephine Radowski			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW 1 215-09-7220		17. INFORMANT Address Mrs Lillian Majerowski, Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 162x Branchogenic Carcinoma DUE TO (b) about 18 yrs Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) about 18 yrs							INTERVAL BETWEEN ONSET AND DEATH about 18 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from March 16, 1923 , to January 3, 1957 , that I last saw the deceased alive on December 26, 1956 , and that death occurred at 11 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Bobby L. Jones MD.				ADDRESS (Street, city or town, state) 104 Chain Survey S			
PHYSICIAN'S NAME (Type) BOBBY L. JONES MD.				DATE SIGNED 1/4/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 7, 1957		22c. NAME OF CEMETERY OR CREMATORY St. Marys		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Hopping and Kirkley				ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE 7 1957	
24b. REGISTRAR'S SIGNATURE L. J. Hall							

BUREAU V. S.

JAN 7 1957

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00149

162 CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
<u>Shady Side</u>				<u>Shady Side</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Christina</u> (Middle) <u>Lorene</u> (Last) <u>Marksberry</u>				(Month) <u>Jan</u> (Day) <u>4</u> (Year) <u>1957</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Female</u>		<u>White</u>		<u>Widow</u>		<u>Jan 22, 1878</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>78</u> yrs.		Months <u>11</u> Days		Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>At Home</u>						<u>Dry Ridge, Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U.S.A.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George Race</u>				<u>Sarah Benson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>				<u>Mrs. H.E. Stallings - Dav</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
157X IMMEDIATE CAUSE (A) <u>Carcinoma pancreas -</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>multiple metastases</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 4</u> , 19 <u>57</u> , to <u>Jan 4</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan 4</u> , 19 <u>57</u> , and that death occurred at <u>3:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Hulim</u>				ADDRESS (Street, city, town, state) <u>Lottsburg, Md.</u>		DATE SIGNED <u>1-4-57</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/8/57</u>				<u>Williamstown, Kentucky</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JAN 7 1957</u>		<u>Ida Belle Dent</u>		<u>Martin W. Hyongbo</u>		<u>Wash. D.C.</u>	

Very truly yours,

BUREAU V.

JAN 7 1957

RECEIVED

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72/8/5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

163

CERTIFICATE OF DEATH

00150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Virginia</i> b. COUNTY <i>Southampton</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>302 Glenwood Ave</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>838-3 Boykins</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Glen Burnie, Maryland</i>				d. STREET ADDRESS <i>R. F. Dr</i>			
3. NAME OF DECEASED (Type or print) First <i>DAVID</i> Middle <i>HILTON</i> Last <i>MARTIN</i>				4. DATE OF DEATH Month <i>January</i> Day <i>25</i> Year <i>1957</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11 Nov. 1873</i>	9. AGE (In years last birthday) <i>83</i> yrs.	10. UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>		11. UNDER 24 HRS. Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mail worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lumber Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Hamilton, N. Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Deceased (unknown)</i>				14. MOTHER'S MAIDEN NAME <i>Deceased (unknown)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT <i>Son - J. W. Martin - 302 Glenwood Ave, Md.</i>		Address <i>Glen Burnie</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intra-abdominal hemorrhage</i> <i>541.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Duodenal ulcer</i> DUE TO (c) <i>Hypertension</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>5 yrs</i> <i>10 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>420.0 arteriosclerotic Heart Disease</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>X</i> 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>X</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 24</i> , 1957, to <i>Jan 25</i> , 1957, that I last saw the deceased alive on <i>Jan 24</i> , 1957, and that death occurred at <i>8:35 PM</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Hubert F. Manuzak</i>		M.D. <i>901 Edgely Rd</i>		ADDRESS (Street, city or town, state) <i>Glen Burnie, Md</i>		DATE SIGNED <i>Jan 26, 1957</i>	
PHYSICIAN'S NAME (Type) <i>HUBERT F. MANUZAK</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>Jan 28, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Scotts Neck Cem</i>		22d. LOCATION (City, town, or county) (State) <i>Scotts Neck, N. Carolina</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. S. Singleton</i>		ADDRESS <i>Glen Burnie, Maryland</i>		24a. REC'D BY REGISTRAR <i>DATE Jan 29, 1957</i>		24b. REGISTRAR'S SIGNATURE <i>L. J. De Alba</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. F.

30 JAN 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

164

CERTIFICATE OF DEATH

00151

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVA</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XORIVA, MD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RIVERVIEW Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1957</u>	
3. NAME OF DECEASED (Type or print) <u>William A. Martin</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Unknown about 20 yrs.</u>		9. AGE (In years last birthday) <u>Unknown about 20 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSURANCE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SALESMAN</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William S. Martin</u>		14. MOTHER'S MAIDEN NAME <u>SARAH Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Edith N. Martin</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardio-vascular disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>dis ease</u> DUE TO (c) <u>104m</u>				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>senile dementia</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>Jan. 5, 1956</u> to <u>Jan. 5, 1956</u> , that I last saw the deceased alive on <u>Jan 5, 1956</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>S. Borosuck</u> M.D. <u>Annapolis Md</u> 1/6/57					
PHYSICIAN'S NAME (Type) <u>S. Borosuck</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-6-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>	
22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Tully + Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>JD</u> DATE		24b. REGISTRAR'S SIGNATURE <u>V. O. Ormick</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John A. Smith"]		SEX [Faint text, possibly "Male"]	
DATE OF BIRTH [Faint text, possibly "1910-01-01"]		PLACE OF BIRTH [Faint text, possibly "New York"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
PLACE OF DEATH [Faint text, possibly "Home"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]	
DATE OF DEATH [Faint text, possibly "1967-01-10"]		SIGNATURE OF DECEASED [Faint text, possibly "John A. Smith"]	
SIGNATURE OF WITNESS [Faint text, possibly "John A. Smith"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "John A. Smith"]	
SIGNATURE OF CLERK [Faint text, possibly "John A. Smith"]		SIGNATURE OF REGISTRAR [Faint text, possibly "John A. Smith"]	

BUREAU V. S.

JAN 10 1967

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completed and filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00152

119 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Prince Georges</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis Md</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Riverdale, Md. 16-25-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Homewood Rest Home</u>				STREET ADDRESS <u>5411 Quintana st.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Mary Emma Mayhew</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 23, 1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 1, 1883</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Arthur A Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Annie Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Joseph A Mayhew Riverdale, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral Vascular Accident</u>						<u>2 mos</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis generalized</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/14</u> , 19 <u>57</u> , to <u>1/23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/22</u> , 19 <u>57</u> , and that death occurred at <u>3:00</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Edward J. Beck</u> M.D.				ADDRESS (Street, city, town, state) <u>41 Southgate Ave Annapolis Md</u> DATE SIGNED <u>1/23/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1/26/57</u>	NAME OF CEMETERY OR CREMATORY <u>Mt Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington D. C.</u>			
24. REC'D BY REGISTRAR <u>Jan 28 1957</u>	REGISTRAR'S SIGNATURE <u>Wm. J. French</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons Hyattsville, Md.</u>				

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THIS IS A SUMMARY OF THE INFORMATION CONTAINED IN THE REPORT OF THE MEDICAL EXAMINER. IT IS NOT A SUBSTITUTE FOR THE ORIGINAL REPORT. THE INFORMATION CONTAINED HEREIN IS FOR INFORMATIONAL PURPOSES ONLY. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. THE INFORMATION CONTAINED HEREIN IS NOT TO BE USED FOR ANY OTHER PURPOSE. THE INFORMATION CONTAINED HEREIN IS NOT TO BE USED FOR ANY OTHER PURPOSE.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Form 10-1-57

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. MANNER OF DEATH

4. CAUSE OF DEATH

5. MEDICAL HISTORY

6. PRESENT ILLNESS

7. TREATMENT

8. POST-MORTEM EXAMINATION

9. SIGNATURE OF MEDICAL EXAMINER

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CLERK

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CONSTABLE

17. SIGNATURE OF TOWNSHIP CLERK

18. SIGNATURE OF COUNTY CLERK

19. SIGNATURE OF STATE CLERK

20. SIGNATURE OF DEPARTMENT CLERK

21. SIGNATURE OF ARCHIVE CLERK

BUREAU V. S.

JAN 28 1957

RECEIVED

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

120

CERTIFICATE OF DEATH

00153

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>West Va</i> b. COUNTY <i>Marion</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Channapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Fairmont</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. C. General</i>		d. STREET ADDRESS <i>85x-3</i>	
3. NAME OF DECEASED (Type or print) <i>Jane</i> First <i>Cook</i> Middle <i>Meredith</i> Last		4. DATE OF DEATH Month <i>1</i> Day <i>31</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-24-1916</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	9. AGE (In years last birthday) <i>40</i> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <i>Marion West Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Arthur S. Clayton</i>		14. MOTHER'S MAIDEN NAME <i>Louise Cook</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs Russell Meredith</i>		Address <i>Fairmont W. Va.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia c/u</i> <i>581.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Alcoholic Cirrhosis</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <i>?</i> <i>?</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11/26/</i> , 1957, to <i>11/31/</i> , 1957, that I last saw the deceased alive on <i>11/30/57</i> , 19____, and that death occurred at <i>6 A</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Frank M. Shipley</i> M.D. <i>63 College Ave</i> <i>11/31/57</i> PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i> <i>Annapolis, Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>1-31-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Fairmont West Va</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		24a. REC'D BY REGISTRAR DATE <i>11/31/57</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>J. P. ...</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 165 CERTIFICATE OF DEATH

00154
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Crownsville</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville State Hospital</i>		d. STREET ADDRESS <i>1117 Harlem Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Florence</i> First <i>Moore</i> Middle <i>Moore</i> Last		4. DATE OF DEATH <i>January</i> Month <i>19</i> Day <i>19</i> Year <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-14-78</i>
9. AGE (In years last birthday) <i>78</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>unemployed</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Clinton Co. N.Y.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>?</i>	
17. INFORMANT <i>John Moore, son</i> Address <i>1117 Harlem Ave</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hypertensive Arteriosclerotic C.V. Disease</i> <i>442x</i> DUE TO <i>Generalized Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>?</i> DUE TO (c) <i>?</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Nephrosclerosis</i>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-20-</i> , 19 <i>56</i> , to <i>1-19</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>1-19-</i> , 19 <i>57</i> , and that death occurred at <i>12:10 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>K. Weber</i>		DATE SIGNED <i>1-20-57</i>	
PHYSICIAN'S NAME (Type) <i>KONSTANTIN WEBER</i>		ADDRESS (Street, city or town, state) <i>Crownsville State Hospital, Crownsville, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-20-57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Catholics</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel W. Sullivan Jr.</i> ADDRESS <i>Balto.</i>		24a. REC'D BY REGISTRAR <i>24-1-1957</i>	24b. REGISTRAR'S SIGNATURE <i>H. M. Joyce</i>

BUREAU V. S.

JAN 24 1957

RECEIVED

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The attending physician or hospital may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

100155

166 CERTIFICATE OF DEATH

Items 3,7,11 FilmG209 1-11-57 et

Reg. Dist. No. 24

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>ANNE ARUNDEL</u>	STATE <u>MARYLAND</u>	CITY <u>Dundalk</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>GLENN BURNIE</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>	COUNTY <u>Baltimore</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MANOR CONVALESCENT HOME</u>	STREET ADDRESS (If rural give location) <u>270 Delk Ct., Dundalk, Maryland</u>		
3. NAME OF DECEASED (Type or Print) <u>MORTON</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>3</u> (Year) <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SEPARATED</u>	8. DATE OF BIRTH <u>1903</u>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S.A. Post Office Clerk</u>		11. BIRTHPLACE (State or foreign country) <u>Charlott Co., Va.</u>	
13. FATHER'S NAME <u>William C. Morton</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Mr. John Morton - 1714 Laurens St.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
331X IMMEDIATE CAUSE (A) <u>CEREBRO-VASCULAR ACCIDENT</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROSIS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>GENERAL</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		21g. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
22. I hereby certify that I attended the deceased from Dec. 1956, to Jan 3, 1957, that I last saw the deceased alive on Dec 30, 1956, and that death occurred at 12:00 P.M. from the causes and on the date stated above.			
SIGNATURE <u>John C. Taylor</u>		DATE SIGNED <u>Jan 3, 1957</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24. REC'D BY REGISTRAR <u>L. J. Sedberry</u>	
DATE THEREOF <u>1/6/57</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>	
LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>	
ADDRESS <u>802 Madison Avenue</u>			

CERTIFICATE OF DEATH

REG. CIV. NO.

PLACE, COUNTY, HOME OR RESIDENCE

MASSACHUSETTS

DECEASED

PLACE OF DEATH

DATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. S.

JAN 7 1957

RECEIVED

RECEIVED

167

CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH a. COUNTY <i>Ad Co</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Ad Co</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Marys</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Marys</i>			
c. LENGTH OF STAY IN 1b <i>16 yrs</i>				d. STREET ADDRESS <i>108 Georgia Ave NW</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>108 Georgia Ave NW</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William E. Oppel</i>				4. DATE OF DEATH <i>Jan 13 1957</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 24 1874</i>	
9. AGE (In years last birthday) <i>82</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stable Boy</i>		10b. MIND OF BUSINESS OR INDUSTRY <i>Barrel Maker</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				13. FATHER'S NAME <i>Michael Oppel</i>			
14. MOTHER'S MAIDEN NAME <i>Mary Bender</i>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>			
16. SOCIAL SECURITY NO. <i>1</i>				17. INFORMANT <i>Mrs Leticia Oppel</i> Address <i>108 Georgia Ave NW</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>Benign Prostatic Hypertrophy</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 mo.</i> <i>5 yrs</i> <i>2-3 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 19, 1956</i> , to <i>Jan 13, 1957</i> , that I last saw the deceased alive on <i>Jan 11, 1957</i> , and that death occurred at <i>6:50 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>C. Milton Linthicum</i>				ADDRESS (Street, city or town, state) <i>106 W. Maple Rd, Linthicum Hgts Md</i>			
PHYSICIAN'S NAME (Type) <i>C. MILTON LINTHICUM</i>				DATE SIGNED <i>1/14/57</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>1/17/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Marys Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Ritchee Heights Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Kowalski</i>				ADDRESS <i>912 S. E. St</i>		24a. REC'D BY REGISTRAR <i>L. J. DeAlba</i>	
				DATE <i>1/15/57</i>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00157

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN lb 10 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 19 Wardour Drive		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 19 Wardour Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Lee Last Ostrander		4. DATE OF DEATH Month 1. Day 17 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1956
9. AGE (In years last birthday) 3 yrs. 23 Months 3 Days 23		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Donald Richard Ostrander		14. MOTHER'S MAIDEN NAME Frances Ann Dunn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Donald R. Ostrander		Address #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis 525X DUE TO Conditions, if any, which gave rise to immediate cause (b) - (c) - DUE TO (a), stating the underlying cause last. (c) -			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-18-57	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor and Sons		ADDRESS Annapolis, Maryland	
24a. REC'D BY REGISTRAR 1/18/57		24b. REGISTRAR'S SIGNATURE Wm. J. French	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner	
John Doe		45		Male		White		Jan 20, 1957		10:30 AM		123 Main St, Boston		Heart Disease		Natural		[Signature]		[Signature]	
Occupation		Education		Marital Status		Previous Illnesses		Alcohol Consumption		Tobacco Use		Last Meal		Last Seen Alive		Witnesses		Burial Place		Burial Date	
Teacher		High School		Married		None		Occasional		Daily		Dinner		Home		Neighbors		Cemetery		Jan 22, 1957	

BUREAU V. S.

JAN 21 1957

RECEIVED

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANN.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *2 RIVA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL Hosp		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HOWARD B. PALMER		4. DATE OF DEATH Month Day Year 1 8 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-1879 77 yrs.
9. AGE (In years last birthday) 77		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TOBACCO FARM		10b. KIND OF BUSINESS OR INDUSTRY FARMER	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME LUTHER A. PALMER		14. MOTHER'S MAIDEN NAME SARAH JANE VISCHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT MRS. ZELLA LEATHERBURY #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Pulmonary Edema 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Cardio Vascular Disease DUE TO (c) yes.		INTERVAL BETWEEN ONSET AND DEATH 1/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/29 , 19 56 , to 1/8 , 19 57 , that I last saw the deceased alive on 1/7 , 19 57 , and that death occurred at 9:45 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Maurice F. Klawans M.D.		ADDRESS (Street, city or town, state) 31 Smithgate W. Annapolis DATE SIGNED 1/10/57	
PHYSICIAN'S NAME (Type) MAURICE F. KLAWANS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-12-57	
22c. NAME OF CEMETERY OR CREMATORY EDWARDS CHAPEL		22d. LOCATION (City, town, or county) (State) ANNAPOLIS MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Galt + Sons ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR DATE 1/15/57	
		24b. REGISTRAR'S SIGNATURE Council	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the funeral director. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be notified. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED LUTHER J. BARNES		AGE 65		SEX Male		RACE White		DATE OF BIRTH 1892		PLACE OF BIRTH Maryland	
MANNER OF DEATH Natural		CAUSE OF DEATH Heart Failure		IMMEDIATE CAUSE Coronary Thrombosis		DISEASE OR INJURY Coronary Artery Disease		PERIOD OF ILLNESS Several days		PLACE OF DEATH Home	
DATE OF DEATH Jan 17, 1957		TIME OF DEATH 10:00 AM		PLACE OF DEATH Home		NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF FUNERAL HOME None		NAME OF NEXT OF KIN Mrs. J. H. Smith	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF FUNERAL HOME None		SIGNATURE OF NEXT OF KIN Mrs. J. H. Smith		SIGNATURE OF DECEASED None		SIGNATURE OF WITNESSES None		SIGNATURE OF REGISTRAR None	

BUREAU V. S.

JAN 17 1957

RECEIVED

168

CERTIFICATE OF DEATH

Reg. Dist. No.

25

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Pk</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Pk</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>14-3rd ave</u>				d. STREET ADDRESS <u>14-3rd ave</u>			
3. NAME OF DECEASED (Type or print) <u>Matilda Pfaff</u>				4. DATE OF DEATH <u>Jan 30, 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 20, 1873</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Balto</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Miller</u>				14. MOTHER'S MAIDEN NAME <u>Mary Vogel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs Edna E. Dawson</u>				Address <u>Brooklyn Pk 14-3rd ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Heart Disease</u> <u>420.0</u> DUE TO (b) <u>Generalized arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6/28, 1955</u> to <u>1/30, 1957</u> that I last saw the deceased alive on <u>1/29, 1957</u> , and that death occurred at <u>5:50 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry Deibel</u> M.D. <u>1226 Hanover St Balto</u>				DATE SIGNED <u>30 Feb</u>			
PHYSICIAN'S NAME (Type) <u>HARRY DEIBEL, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. H. Evans</u> ADDRESS <u>1400 S. Charles</u>				24a. REC'D BY REGISTRAR <u>EB 4</u> DATE <u>1957</u>			
24b. REGISTRAR'S SIGNATURE <u>John Whitson</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES H. HARRIS		45		M		W		FEB 10 1957	
PLACE OF DEATH		RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
HARRIS HOME		1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARITAL STATUS		RELIGION	
FEB 10 1912		BALTIMORE, MD.		8 YEARS		MARRIED		METHODIST	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH	
NONE		FEB 8 1957		FEB 10 1957		10:00 AM		10:00 AM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
FEB 10 1957		FEB 10 1957		FEB 10 1957		FEB 10 1957		FEB 10 1957	

BUREAU V. S.

FEB 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

169

CERTIFICATE OF DEATH

Reg. Dist. No.

00160

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>506 Munroe Circle</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marye R. Phelps</u>				4. DATE OF DEATH Month Day Year <u>January 3, 19 57</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 4, 1871</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Montgomery Co., Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Isaac N. Shipley</u>				14. MOTHER'S MAIDEN NAME <u>Marbary J. Pyles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>--</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Charles Purdum</u> Address <u>404 Second Ave., SW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1936</u> , to <u>Jan. 3, 1957</u> , that I last saw the deceased alive on <u>Jan. 2, 1957</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>108 Central Ave, Glen Burnie</u> DATE SIGNED <u>1/3/57</u>							
ACTUAL SIGNATURE <u>James S. Billingslea</u> M.D.							
PHYSICIAN'S NAME (Type) <u>James S. Billingslea</u> M.D.				Glen Burnie, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan 4, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>L. J. DeCeba</u>	

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Married		Occupation	
John Doe		35 yrs.		Male		White		Single		Farmer	
Date of Death		Place of Death		Cause of Death		Disease		Duration		Signature	
Jan 1, 1957		Home		Heart Disease		Myocardial Infarction		2 weeks		[Signature]	
Time of Death		Manner of Death		Place of Burial		Burial		Interment		Signature	
10:00 AM		Natural		Cemetery		Buried		Interred		[Signature]	
Time of Burial		Place of Burial		Cause of Death		Disease		Duration		Signature	
1:00 PM		Cemetery		Heart Disease		Myocardial Infarction		2 weeks		[Signature]	

BUREAU V. R.

JAN 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

00161

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 2mos. 20 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessups 13x0 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Route #1, Box 269		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Martha Phillips				4. DATE OF DEATH Month Day Year 1 11 19 57			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
9. AGE (In years last birthday) yrs. 76?		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Not listed		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Robert Dansic				14. MOTHER'S MAIDEN NAME Beckie Dansic			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221 (b) Cerebrovascular Accident DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic cardiovascular disease and Senility							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/16 , 19 56 , to 1/11 , 19 57 , that I last saw the deceased alive on 1/11 , 19 57 , and that death occurred at 4:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 1/12/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 16 1957		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY St. Mary's		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. H. Williams		ADDRESS 322 N. ...		24a. REC'D BY REGISTRAR 1/15/57		24b. REGISTRAR'S SIGNATURE Ed. M. Joyce	

BUREAU V. S.

JAN 16 1957

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9 Film G209 1-11-57 et

CERTIFICATE OF DEATH

00162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> , MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville Md.</u>				c. LENGTH OF STAY IN 1b <u>5 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sanns Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henrietta</u> Middle <u>Poole</u> Last <u>Poole</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 19 1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Jules Nunthel</u>				14. MOTHER'S MAIDEN NAME <u>Sarah ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>110</u>		17. INFORMANT Address <u>Daughter Mrs Manning Severna Park Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> , 19 <u>57</u> , to <u>Jan 1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>56</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park Md.</u> DATE SIGNED <u>1-4-57</u> ACTUAL SIGNATURE <u>Robert R. Hahn</u> PHYSICIAN'S NAME (Type) <u>Robert R. Hahn</u> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McGully Funeral Homes</u>				ADDRESS <u>130 E. Fort Ave.</u>		24a. REC'D BY REGISTRAR <u>1957</u> 24b. REGISTRAR'S SIGNATURE <u>H. M. Joyce</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1928		5. PLACE OF BIRTH Jackson, Mississippi	
6. OCCUPATION Attorney		7. MARITAL STATUS Single		8. RACE White		9. RELIGION Methodist		10. EDUCATION High School	
11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. PLACE OF DEATH Baltimore, Maryland		14. DATE OF DEATH Jan 4, 1968		15. TIME OF DEATH 11:00 AM	
16. SIGNATURE OF PHYSICIAN J. Edgar Hoover		17. SIGNATURE OF CORONER J. Edgar Hoover		18. SIGNATURE OF DECEASED J. Edgar Hoover		19. SIGNATURE OF WITNESS J. Edgar Hoover		20. SIGNATURE OF REGISTRAR J. Edgar Hoover	

BUREAU V. S.

JAN 4 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00163

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CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Powell</u> Last <u>Powell</u>				4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>19 57</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 14, 1902</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u> Hours <u>-</u> Min. <u>-</u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>		11. BIRTHPLACE (State or foreign country) <u>U. S.</u>	
13. FATHER'S NAME <u>John T. Powell</u>				14. MOTHER'S MAIDEN NAME <u>Not given</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT <u>Crownsville State Hospital</u> <u>Crownsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u> DUE TO (b) <u>Pleural effusion and Pleuritis - right lung</u> DUE TO (c) <u>Pulmonary Tuberculosis, congestive heart failure and General Paresis of</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>the Insane</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Form 18.) <u>the Insane</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Crownsville, Md.</u>		(County)		(State)	
21. I certify that I attended the deceased from <u>7/10</u> , 19 <u>56</u> , to <u>1/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/17</u> , 19 <u>57</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>1/17/57</u> ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/21/57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Nelson</u>				ADDRESS <u>1348 Calhoun St.</u>		24b. REC'D BY REGISTRAR <u>19/19/57</u>	
				24c. REGISTRAR'S SIGNATURE <u>R. M. Jagers</u>			

RECEIVED

1. PLACE OF DEATH a. COUNTY AA MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY AA		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena			c. LENGTH OF STAY IN 1b YRS.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mountain Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Fred. Middle C. Last Reinhardt			4. DATE OF DEATH Month 1 Day 2 Year 19 57		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/17/88	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.			10b. KIND OF BUSINESS OR INDUSTRY Stand. States. Coop.		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Unk.		
14. MOTHER'S MAIDEN NAME UNK.			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		
16. SOCIAL SECURITY NO. 217 09 9244			17. INFORMANT Family		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 4 hours		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from September 10, 19 54 to January 2, 19 57 , that I last saw the deceased alive on January 2, 19 57 , and that death occurred at 5:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pasadena, Md. DATE SIGNED January 2, 1957					
ACTUAL SIGNATURE R. M. McLaughlin			PHYSICIAN'S NAME (Type) R. M. McLaughlin		
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 1/5/57		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	
22d. LOCATION (City, town, or county) (State) Baltimore, Md.		23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave.			
24a. REC'D BY REGISTRAR AN 4		24b. REGISTRAR'S SIGNATURE L. J. Seabury			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF BURIAL OFFICIAL		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF CHURCH	
16. SIGNATURE OF CEMETERY		17. SIGNATURE OF INTERVIEWER		18. SIGNATURE OF INTERVIEWEE	
19. SIGNATURE OF INTERVIEWER		20. SIGNATURE OF INTERVIEWEE		21. SIGNATURE OF INTERVIEWER	
22. SIGNATURE OF INTERVIEWEE		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWEE	
25. SIGNATURE OF INTERVIEWER		26. SIGNATURE OF INTERVIEWEE		27. SIGNATURE OF INTERVIEWER	
28. SIGNATURE OF INTERVIEWEE		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWEE	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWEE		33. SIGNATURE OF INTERVIEWER	
34. SIGNATURE OF INTERVIEWEE		35. SIGNATURE OF INTERVIEWER		36. SIGNATURE OF INTERVIEWEE	
37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWEE		39. SIGNATURE OF INTERVIEWER	
40. SIGNATURE OF INTERVIEWEE		41. SIGNATURE OF INTERVIEWER		42. SIGNATURE OF INTERVIEWEE	
43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWEE		45. SIGNATURE OF INTERVIEWER	
46. SIGNATURE OF INTERVIEWEE		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWEE	
49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWEE		51. SIGNATURE OF INTERVIEWER	
52. SIGNATURE OF INTERVIEWEE		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWEE	
55. SIGNATURE OF INTERVIEWER		56. SIGNATURE OF INTERVIEWEE		57. SIGNATURE OF INTERVIEWER	
58. SIGNATURE OF INTERVIEWEE		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWEE	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWEE		63. SIGNATURE OF INTERVIEWER	
64. SIGNATURE OF INTERVIEWEE		65. SIGNATURE OF INTERVIEWER		66. SIGNATURE OF INTERVIEWEE	
67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWEE		69. SIGNATURE OF INTERVIEWER	
70. SIGNATURE OF INTERVIEWEE		71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWEE	
73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWEE		75. SIGNATURE OF INTERVIEWER	
76. SIGNATURE OF INTERVIEWEE		77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWEE	
79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWEE		81. SIGNATURE OF INTERVIEWER	
82. SIGNATURE OF INTERVIEWEE		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWEE	
85. SIGNATURE OF INTERVIEWER		86. SIGNATURE OF INTERVIEWEE		87. SIGNATURE OF INTERVIEWER	
88. SIGNATURE OF INTERVIEWEE		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWEE	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWEE		93. SIGNATURE OF INTERVIEWER	
94. SIGNATURE OF INTERVIEWEE		95. SIGNATURE OF INTERVIEWER		96. SIGNATURE OF INTERVIEWEE	
97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWEE		99. SIGNATURE OF INTERVIEWER	
100. SIGNATURE OF INTERVIEWEE		101. SIGNATURE OF INTERVIEWER		102. SIGNATURE OF INTERVIEWEE	

BUREAU V. S.

JAN 4 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

171

CERTIFICATE OF DEATH

00165
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEO G MEADE				c. LENGTH OF STAY IN 1b 5 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S.A.H.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JERRY Middle IRVING Last RUBIN				4. DATE OF DEATH Month JANUARY Day 7 Year 19 57			
5. SEX MALE		6. COLOR OR RACE CAU		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 14, 1904	
9. AGE (In years last birthday) 52 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SOLDIER, US ARMY		10b. KIND OF BUSINESS OR INDUSTRY US ARMY		11. BIRTHPLACE (State or foreign country) New York	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Simon Rubin		14. MOTHER'S MAIDEN NAME Sarah Storick		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	
16. SOCIAL SECURITY NO.		17. INFORMANT MRS. SEIMA ZEIKIND		Address 67 DEBBIE PLACE, BERKELEY HTS NEW JERSEY		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infaret with Heart Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH 5 months		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from June , 19 55 , to 7 Jan , 19 57 , that I last saw the deceased alive on 5 Jan , 19 57 , and that death occurred at 1:15 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE John F. McDonnell		M.D. U. S. ARMY HOSPITAL, FGGM, Md.		7 Jan 57		PHYSICIAN'S NAME (Type) JOHN F. MCDONNELL	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9 Jan 57		22c. NAME OF CEMETERY OR CREMATORY Old Montefiore Cemetery		22d. LOCATION (City, town, or county) (State) Queens County, New York	
23. FUNERAL DIRECTOR'S SIGNATURE I J MORRIS, INC.		ADDRESS 9701 Church Avenue, Brooklyn,		DATE 7 Jan 57		REC'D BY REGISTRAR W.L. Saylor	

PLAYERS STATE DEPARTMENT OF HEALTH—BALTIMORE, 10

JAN 10 1957

27991

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

001668

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6mos. 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Scarborough Last Scarborough		4. DATE OF DEATH Month 1 Day 21 Year 1957	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1893	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not listed		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Horace Scarborough		14. MOTHER'S MAIDEN NAME Mary London	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. _____ p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/12 , 19 56 , to 1/21 , 19 57 , that I last saw the deceased alive on 1/21 , 19 57 , and that death occurred at 10:05 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 1/22/57			
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Lionel McHenry Mapp, M. D.	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-26-57	
22c. NAME OF CEMETERY OR CREMATORY mt auburn		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Pro. S. Nelson		ADDRESS 1348 N. Calhoun St	
24a. REC'D BY REGISTRAR 1/24/57		24b. REGISTRAR'S SIGNATURE H. M. Joyce	

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JAN 24 1957

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00167

123

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>H.A. GENERAL Hospt.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MICHAEL PARKER SCHWALIER</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-56</u>	9. AGE (in years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>ANDREW M. SCHWALIER</u>			
14. MOTHER'S MAIDEN NAME <u>KATHERINE E. BYTHER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>ANDREW M. SCHWALIER #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial pneumonia</u> <u>763.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>12/29</u> , 19 <u>56</u> , to <u>1/1</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>12/30</u> , 19 <u>56</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph C. Sheehan</u> M.D.				ADDRESS (Street, city or town, state) <u>69 Franklin</u>			
NAME (Type) <u>JOSEPH C. SHEEHAN</u>				DATE SIGNED <u>Annapolis, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-3-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>1/4/57</u>	
24b. REGISTRAR'S SIGNATURE <u>John J. French</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00168

175

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>a a</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Galesville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Galesville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Walter</i> Middle <i>Edward</i> Last <i>Seicke</i>				4. DATE OF DEATH Jan 26 1957			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 8 1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Homes</i>		11. BIRTHPLACE (State or foreign country) <i>Catonville Md</i>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <i>Frederick E Seicke</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>214 350377</i>		17. INFORMANT <i>Eochy Hartge</i> Address <i>Galesville Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of bladder</i> <i>181X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>E Metastasis to liver</i> DUE TO (c) <i>kidneys, lungs etc</i>							INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>March</i> 1955, to <i>January</i> 1957, that I last saw the deceased alive on <i>22 January</i> 1957, and that death occurred at <i>3:00 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>F D Hendricks</i> M.D.				ADDRESS (Street, city or town, state) <i>Shady Side, Maryland</i>			
PHYSICIAN'S NAME (Type) <i>F D Hendricks</i>				DATE SIGNED <i>March 26 1957</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/29/57</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Louisa Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Burial Society Galesville Md</i> ADDRESS				24a. REC'D BY REGISTRAR <i>Wm J. 2919857</i>		24b. REGISTRAR'S SIGNATURE <i>Wm J. 2919857</i>	

JAN 31 1957

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CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Port</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Port</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>205 Chester Ave.</u>		d. STREET ADDRESS <u>205 Chester Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>Shaw</u> Last <u>Shaw</u>		4. DATE OF DEATH Month <u>1</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-1872</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>11</u>	IF UNDER 24 HRS. Hours <u>11</u> Min. <u>57</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Captain</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>West River, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT Address <u>Josephine Coates - 418 Chester Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>?</u> DUE TO (c) <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>?</u> a. m. <u>19</u> p. m. <u>?</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-11-57</u> , 19 <u>57</u> to <u>1-11-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-11-57</u> , 19 <u>57</u> , and that death occurred at <u>3:55</u> PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. L. Coates</u>		ADDRESS (Street, city or town, state) <u>611 Chestnut St</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>		DATE SIGNED <u>1-11-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-15-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. Annapolis</u>		ADDRESS <u>?</u>	
24a. REC'D BY REGISTRAR <u>?</u>		24b. REGISTRAR'S SIGNATURE <u>Wm J French</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>John Doe</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. RACE <i>White</i></p>	
<p>5. DATE OF DEATH <i>Jan 10 1957</i></p>		<p>6. TIME OF DEATH <i>10:00 AM</i></p>	
<p>7. PLACE OF DEATH <i>Home</i></p>		<p>8. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>9. DISEASE OR INJURY <i>Myocardial Infarction</i></p>		<p>10. MANNER OF DEATH <i>Natural</i></p>	
<p>11. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>		<p>12. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>	
<p>13. SIGNATURE OF WITNESS <i>[Signature]</i></p>		<p>14. SIGNATURE OF DECEASED <i>[Signature]</i></p>	

BUREAU V. S.

JAN 14 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00179

178

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 4months25days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital				d. STREET ADDRESS 556 Oxford Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Isaac Middle Sheridan Last Sheridan				4. DATE OF DEATH Month 1 Day 16 Year 19 57			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
9. AGE (In years last birthday) 60? yrs.		IF UNDER 1 YEAR Months — Days —		IF UNDER 24 HRS. Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.				10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) Not given	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic cardiovascular disease DUE TO Cerebral atrophy Cerebro-spinal syphilis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebro-spinal syphilis							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 8/22 , 19 56 , to 1/16 , 19 57 , that I last saw the deceased alive on 1/16 , 19 57 , and that death occurred at 4:25 p. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Maryland DATE SIGNED 1/17/57							
ACTUAL SIGNATURE L. Benedict				M.D. Ludwig Benedict, M. D.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/57		22c. NAME OF CEMETERY OR CREMATORY National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas E. Velsing				ADDRESS 1303 Chestnut St. Baltimore, Md.		24a. REC'D BY REGISTRAR JAN 25 1957	
24b. REGISTRAR'S SIGNATURE F. M. Joyce							

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 5, 1922		5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION Minister		7. MARITAL STATUS Single		8. COLOR White	
9. DATE OF DEATH Jan 4, 1968		10. PLACE OF DEATH Baltimore, Maryland		11. CAUSE OF DEATH Suicide		12. MANNER OF DEATH Homicide		13. ICD-9 CODE 270.21		14. MEDICAL HISTORY None		15. PREVIOUS ILLNESS None		16. SIGNATURE OF PHYSICIAN J. Edgar Hoover	
17. SIGNATURE OF DECEASED James Earl Ray		18. SIGNATURE OF WITNESS John Edgar Hoover		19. SIGNATURE OF PHYSICIAN J. Edgar Hoover		20. SIGNATURE OF CORONER John Edgar Hoover		21. SIGNATURE OF JURY John Edgar Hoover		22. SIGNATURE OF JUDGE John Edgar Hoover		23. SIGNATURE OF CLERK John Edgar Hoover		24. SIGNATURE OF NOTARY John Edgar Hoover	
25. SIGNATURE OF DECEASED James Earl Ray		26. SIGNATURE OF WITNESS John Edgar Hoover		27. SIGNATURE OF PHYSICIAN J. Edgar Hoover		28. SIGNATURE OF CORONER John Edgar Hoover		29. SIGNATURE OF JURY John Edgar Hoover		30. SIGNATURE OF JUDGE John Edgar Hoover		31. SIGNATURE OF CLERK John Edgar Hoover		32. SIGNATURE OF NOTARY John Edgar Hoover	

BUREAU V. 8

JAN 25 1968

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00171

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CERTIFICATE OF DEATH

Reg. Dist. No.

22

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Linthicum Hgts.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>438 Shipley Rd.</u>		d. STREET ADDRESS <u>1 438 Shipley Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Wm</u> First <u>Braham</u> Middle <u>Sinclair</u> Last		4. DATE OF DEATH <u>Jan 4</u> Month <u>1957</u> Day Year	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/28/96</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rigger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ship -</u>	
11. BIRTHPLACE (State or foreign country) <u>South Africa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hugh M. Sinclair</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>214-03-2278</u>	
17. INFORMANT <u>Christive Sinclair</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1956</u> to <u>1/4/57</u> , 19____, that I last saw the deceased alive on <u>1/4/57</u> , 19____, and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Linthicum Md</u>	
DATE SIGNED <u>1/4/57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Charles L. Ball, Jr.</u>		<u>Linthicum, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/8/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Bernie AA Co. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Cully Funeral Home</u> ADDRESS <u>130 E. Fort Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 10 1957</u>	24b. REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIAGE		MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		OTHER			
OCCUPATION		PROFESSION		VOCATION		INDUSTRY		BUSINESS		ART		SCIENCE		LITERATURE	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		GRADUATE		POSTGRADUATE		OTHER			
RELIGION		METHODIST		BAPTIST		CATHOLIC		LUTHERAN		PRESBYTERIAN		OTHER			
CAUSE OF DEATH		DISEASE		INJURY		POISON		SUICIDE		HOMICIDE		OTHER			
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		HOSPITAL			
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MINISTER			

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JAN 10 1957
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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CERTIFICATE OF DEATH

00172

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAVIDSONVILLE</u> x1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. NAVAL HOSPITAL, ANNAPOLIS MD</u>				d. STREET ADDRESS <u>RT #1 BOX 58A</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Baby Girl SMITH</u>				4. DATE OF DEATH Month Day Year <u>January 13 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12 JAN 57</u>	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -- -- --				10b. KIND OF BUSINESS OR INDUSTRY -- -- --			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Edgar Harold SMITH</u>				14. MOTHER'S MAIDEN NAME <u>Keiko SUGIYAMA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -- -- --		17. INFORMANT Address <u>U.S. Naval Hospital, Annapolis, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12 January, 1957</u> , to <u>13 January 1957</u> , that I last saw the deceased alive on <u>13 January</u> 19 <u>57</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Francesco DePaola</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Francesco DE PAOLA LT MC USNR</u>				U.S. NAVAL HOSPITAL, ANNAPOLIS MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-14-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANNAPOLIS NECK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR *SON</u>				ADDRESS <u>ANNAPOLIS MD.</u>		24a. REC'D BY REGISTRAR DATE <u>1/15/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

JAN 17

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00173

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Geo. G. Meade</u>		LENGTH OF STAY (In this place) <u>3 Weeks</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>US Army Hospital, Fort George G Meade, Maryland</u>				STREET ADDRESS (If rural give location) <u>3601.4 610 Cathedral Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>EVA</u> <u>MAE</u> <u>SMITH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 19</u> <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>July 7, 1911</u>	9. AGE last birthday <u>45</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk Social Security Adm.</u>			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Bedford, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Elmer Head</u>				14. MOTHER'S MAIDEN NAME <u>Grace Grey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Rt 1 Box 10</u> <u>Lt. Thomas E. Smith, Finksburg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>199.9</u> IMMEDIATE CAUSE (A) <u>Sarcomatosis, disseminated</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>28 December, 56</u> , to <u>19 January, 57</u> , that I last saw the deceased alive on <u>19 Jan</u> , 19 <u>57</u> , and that death occurred at <u>3:00p</u> M., from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>US Army Hospital, Fort George G Meade, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/11/1957</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>21 Jan 57</u>		REGISTRAR'S SIGNATURE <u>W. L. SAYLOR, 1/Lt MSC</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck 5305 Harford Road.</u>			

BUREAU V. S.

JAN 22 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00174

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CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 2 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Isiah Middle Smith Last Smith				4. DATE OF DEATH Month 1 Day 20 Year 19 57			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-27-1890	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 03 Days 52	IF UNDER 24 HRS. Hours 22 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Cooksville, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Smith				14. MOTHER'S MAIDEN NAME Mariah Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Hospital Records Address Crownsville State Hospital Crownsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cavernous Sinus Thrombosis DUE TO (c) Cellulitis of the face							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/30 , 19 56 , to 1/20 , 19 57 , that I last saw the deceased alive on 1/18 , 19 57 , and that death occurred at 12:30 p.m. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lurel McKury Mapp				ADDRESS (Street, city or town, state) Crownsville, Md.		DATE SIGNED 1/21/57	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 1/24/57		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY National Cemetery Baltimore Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higginbotham				ADDRESS Ellicott City, Md.		24a. REC'D BY REGISTRAR DATE 23 1957	
				24b. REGISTRAR'S SIGNATURE F. M. Joyner			

3

4561

JAN 23

BUREAU V. S.

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

00175

Reg. Dist. No.

182

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3v01-4	
c. LENGTH OF STAY IN b. 7mos. 27days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 752 N. Gay Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mamie Middle Souza Last Souza		4. DATE OF DEATH Month 1 Day 16 Year 19 57	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given Aug. 15. 53
9. AGE (In years last birthday) yrs. 53		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Not given Chester Sc.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Anderson		14. MOTHER'S MAIDEN NAME Lucy Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular accident with right hemiplegia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Hypertensive cardiovascular disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/13 , 19 56 , to 1/16 , 19 57 , that I last saw the deceased alive on 1/16 , 19 57 , and that death occurred at 11:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 1/16/57 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/19/57	
22c. NAME OF CEMETERY OR CREMATORY mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Williams		24a. REC'D BY REGISTRAR DATE 1/18/57	
ADDRESS 322 N. Schrock St		24b. REGISTRAR'S SIGNATURE X. M. Joyce	

CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]		CITY [Illegible]	
COUNTY [Illegible]		STATE [Illegible]		ZIP CODE [Illegible]	
OCCUPATION [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]	
MEDICAL HISTORY [Illegible]		PREVIOUS ILLNESS [Illegible]		PREVIOUS SURGERY [Illegible]	
PHYSICIAN'S SIGNATURE [Illegible]		MEDICAL EXAMINER'S SIGNATURE [Illegible]		CORONER'S SIGNATURE [Illegible]	
DATE OF SIGNATURE [Illegible]		PLACE OF SIGNATURE [Illegible]		CITY [Illegible]	
COUNTY [Illegible]		STATE [Illegible]		ZIP CODE [Illegible]	

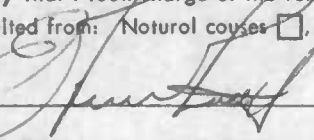
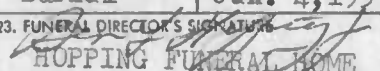
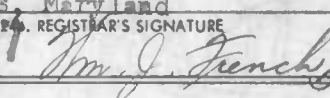
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 BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 21

00176

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 Gambrills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Anne Arundel General Hospital			d. STREET ADDRESS Defence Highway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle R Last SPENCER			4. DATE OF DEATH Month JANUARY Day 2 Year 19 57		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1892		9. AGE (In years last birthday) 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY lumber mill		11. BIRTHPLACE (State or foreign country) Carroll, Virginia	
13. FATHER'S NAME Jefferson D. Spencer			14. MOTHER'S MAIDEN NAME Margaret Spencer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 216-12-6422		17. INFORMANT Address Mrs Lora V. O'Dell- Sister- same as # 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 812X Fractured Skull, Fracture Cervical Spine, DUE TO Crushing injuries to chest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Compound Fracture of Right Tibia and Fibula					INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) was struck by auto while walking on road			
20c. TIME OF INJURY Month, Day, Year 3:25 p.m. Jan. 2 19 57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt 450	
				20f. (City or town) (County) (State) Gambrills, Anne Arundel, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural cause <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED January 2, 1957	
EXAMINER'S NAME (Type) Elmer J. Linhardt		M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 4, 1957		22c. NAME OF CEMETERY OR CREMATORY National Cemetery	
				22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS HOPPING FUNERAL HOME Annapolis, Md.		24a. REC'D BY REGISTRAR JAN 7 1957	
				24b. REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JAN 7 1957

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126

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Annapolis) Mulberry Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Perry</u> <u>STANSBURY</u>				4. DATE OF DEATH Month Day Year <u>1</u> <u>17</u> <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-16-1891</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cement Finisher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>North Severn Public Works</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Perry Stansbury</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Harriod</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I.</u>				16. SOCIAL SECURITY NO. <u>214-05-2356</u>			
17. INFORMANT <u>Norman Stansbury - Mulberry Hill, Md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive arteriosclerotic cardiovascular disease</u> DUE TO <u>443X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>7 hr</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>1/12</u> , 19 <u>52</u> , to <u>1/12</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/12</u> , 19 <u>57</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>90 Cathedral St. Annapolis, Md.</u> DATE SIGNED <u>1/18/57</u>							
ACTUAL SIGNATURE <u>John L. Bradman</u> M.D.				PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-21-57</u>		<u>Broad Neck</u>		<u>Skidmore, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II - Annapolis, Md</u>				24a. REC'D BY REGISTRAR <u>Wm. J. French</u>			
ADDRESS				DATE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. Page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No.

25

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>5013 BROOKLYN PARK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11 3RD AVE.</u>				d. STREET ADDRESS <u>11 3RD AVE.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>STEPHEN SYNOWSKI</u>				4. DATE OF DEATH Month Day Year <u>JAN 4 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 15, 1876</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SUGAR BOILER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AMER. SUGAR</u>		11. BIRTHPLACE (State or foreign country) <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>HENRY SYNOWSKI</u> Address <u>11 3RD AVE. (25)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Hypertensive Cardiac vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 15, 1956</u> to <u>Jan. 4, 1957</u> , that I last saw the deceased alive on <u>11/3/57</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Samuel Rubin</u> M.D.				ADDRESS (Street, city or town, state) <u>203 Petrosone Ave Baltimore Md</u> DATE SIGNED <u>Jan 25 1957</u>			
PHYSICIAN'S NAME (Type) <u>SAMUEL RUBIN MD</u>				<u>Baltimore Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS CO</u>		22d. LOCATION (City, town, or county) (State) <u>ANNE ARUNDEL CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gorce</u>				ADDRESS <u>4601 Ritchie Hwy</u>		24a. REC'D BY REGISTRAR <u>JAN 9 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Ida M. Hutson</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF BURIAL	
19. SIGNATURE OF INTERMENT		20. SIGNATURE OF FUNERAL HOME		21. SIGNATURE OF CEMETERY	
22. SIGNATURE OF CHURCH		23. SIGNATURE OF MINISTERS		24. SIGNATURE OF MUSICIANS	
25. SIGNATURE OF OTHERS		26. SIGNATURE OF OTHERS		27. SIGNATURE OF OTHERS	
28. SIGNATURE OF OTHERS		29. SIGNATURE OF OTHERS		30. SIGNATURE OF OTHERS	
31. SIGNATURE OF OTHERS		32. SIGNATURE OF OTHERS		33. SIGNATURE OF OTHERS	
34. SIGNATURE OF OTHERS		35. SIGNATURE OF OTHERS		36. SIGNATURE OF OTHERS	
37. SIGNATURE OF OTHERS		38. SIGNATURE OF OTHERS		39. SIGNATURE OF OTHERS	
40. SIGNATURE OF OTHERS		41. SIGNATURE OF OTHERS		42. SIGNATURE OF OTHERS	
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52. SIGNATURE OF OTHERS		53. SIGNATURE OF OTHERS		54. SIGNATURE OF OTHERS	
55. SIGNATURE OF OTHERS		56. SIGNATURE OF OTHERS		57. SIGNATURE OF OTHERS	
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64. SIGNATURE OF OTHERS		65. SIGNATURE OF OTHERS		66. SIGNATURE OF OTHERS	
67. SIGNATURE OF OTHERS		68. SIGNATURE OF OTHERS		69. SIGNATURE OF OTHERS	
70. SIGNATURE OF OTHERS		71. SIGNATURE OF OTHERS		72. SIGNATURE OF OTHERS	
73. SIGNATURE OF OTHERS		74. SIGNATURE OF OTHERS		75. SIGNATURE OF OTHERS	
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97. SIGNATURE OF OTHERS		98. SIGNATURE OF OTHERS		99. SIGNATURE OF OTHERS	
100. SIGNATURE OF OTHERS		101. SIGNATURE OF OTHERS		102. SIGNATURE OF OTHERS	

BUREAU V. S.

JAN 2 1957

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The original copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 7,13,14 FilmG210 1-29-57 et

127 CERTIFICATE OF DEATH

00179

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>ANNE ARUNDEL</u>		MARYLAND		STATE		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>ANNAPOLIS</u>				TOWN <u>TRACYS LANDING</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A.A. GENERAL</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>John Taylor</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 14 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Separated</u>	8. DATE OF BIRTH		9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALT. CITY</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Bonnett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>214-12-4123</u>		17. INFORMANT & ADDRESS <u>FANNY BONNETT</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Acute Pulmonary Edema & hremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral Vascular Accident</u>				<u>36 hrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>arteriosclerosis, generalized</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/13/57</u> , 19 <u>57</u> , to <u>1/14/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1/14/57</u> , 19 <u>57</u> , and that death occurred at <u>230 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Shipley</u>				DATE SIGNED <u>M.D. 63 College Ave Annapolis 1/15/57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-15-57</u>		NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>		LOCATION (City, town, or county) (State) <u>3rd Kendra Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard D. Hedrick</u>		ADDRESS	
DATE <u>1/22/57</u>							

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00180

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort George G. Meade</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>--</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 3V01-4</u> STREET ADDRESS (If rural give location) <u>3012 Hanlon Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>AMELIA MARIA THOMAS</u>			4. DATE OF DEATH January 26 19 57				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>25 January 1957</u>	9. AGE last birthday yrs. <u>12</u> Months <u>26</u> Days <u>26</u> Hours <u>12</u> Min.	10. IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>James William Thomas</u>				
14. MOTHER'S MAIDEN NAME <u>Amelia Maria Kelly</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT & ADDRESS <u>Mother, 3012 Hanlon Avenue, Baltimore, Md.</u>				
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 7620 IMMEDIATE CAUSE (A) <u>Anoxia</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Atelectasis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Atresia of rectum?? Congenital heart disease</u>				18. MEDICAL CERTIFICATION <u>Anoxia</u> <u>Atelectasis</u> <u>Atresia of rectum?? Congenital heart disease</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)			
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>25 Jan., 19 57</u> , to <u>26 Jan., 19 57</u> , that I last saw the deceased alive on <u>26 Jan., 19 57</u> , and that death occurred at <u>11:35 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Richard M. McGuane</u>		RICHARD M. MCGUANE, CAPT, MC M.D. <u>2101-150, USAH, Ft. Meade</u>		DATE SIGNED <u>26 Jan 57</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1 Feb 57</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>			
24. REC'D BY REGISTRAR <u>W.L. Saylor, 1st Lt, MSC</u>		REGISTRAR'S SIGNATURE <u>W.L. Saylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arington S. Phillips</u>			
DATE <u>28 Jan 57</u>		ADDRESS <u>Baltimore, Md.</u>		ADDRESS <u>Baltimore, Md.</u>			

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128

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>48 Randall Street</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 5, 1897</u>		9. AGE (In years lost birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Thompson</u>				14. MOTHER'S MAIDEN NAME <u>Mary M. Cranford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I none</u>		17. INFORMANT Address <u>William J. Thompson Jr. Son Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u> <u>3 hr.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/11/57</u> , 19 <u>57</u> to <u>1/12/57</u> , that I last saw the deceased alive on <u>1/12/57</u> , 19 <u>57</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u>				ADDRESS (Street, city or town, state) <u>63 College Ave. Annapolis, Maryland</u>		DATE SIGNED <u>1/14/57</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley MD</u>				<u>63 College Ave. Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-15-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPKINS FUNERAL HOME</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE <u>V. Orsini</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

001824
33

185

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold			c. LENGTH OF STAY IN 1b 4 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Grand View Ave.				d. STREET ADDRESS Grand View Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Guy Middle Steele Last Tregoe Sr.				4. DATE OF DEATH Month Jan. Day 15 Year 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 5, 1901		9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore City		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William E. Tregoe				14. MOTHER'S MAIDEN NAME Mary Linda Seymour			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-07-5412		17. INFORMANT Address Guy S. Tregoe Jr./Reisterstown, Md.			
18. CAUSE OF DEATH [Enter only one cause and line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant tumor of Brain 193X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 8 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 19, 1956 , to January 16, 1957 , that I last saw the deceased alive on January 13, 1957 , and that death occurred at 10:15 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Maurice F. Klawans		M.D. 315 Mt. Airy Ave., Baltimore, Md.		DATE SIGNED 1/16/57			
PHYSICIAN'S NAME (Type) MAURICE F. KLAWANS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-18-57		22c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Garden, Finksburg, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.				24a. REC'D BY REGISTRAR DATE 1-16-57		24b. REGISTRAR'S SIGNATURE Robert D. [Signature]	

and we have

WILLIAM T. BRYANT

186

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pines on Severn</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x0 Pines on Severn Arnold</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Path Old River Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert Benson Turner.</u>			4. DATE OF DEATH Jan. 27 1957.				
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1889</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Leonidas G. Turner.</u>			14. MOTHER'S MAIDEN NAME <u>Amelia Archer.</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>U.S. Army 1917-1929</u>			16. SOCIAL SECURITY NO. <u>1917-1929</u>		17. INFORMANT Address <u>wife - Mrs Turner - Pines on Severn</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Carcinoma</u> <u>162X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> , 19 <u>57</u> , to <u>Jan</u> 19 <u>57</u> , that I last saw the deceased alive on <u>Jan</u> 19 <u>57</u> , and that death occurred at <u>3:23 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Severna Park md - 27-57</u> DATE SIGNED <u>MD</u>							
ACTUAL SIGNATURE <u>Robert R. HAHN.</u> M.D.				PHYSICIAN'S NAME (Type) <u>Robert R. HAHN.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-30-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ardencrest National</u>		22d. LOCATION (City, town, or county) (State) <u>Ardencrest Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr</u> ADDRESS <u>Annapolis</u>				24a. REC'D BY REGISTRAR <u>1/29/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JAN 30 1957

BUREAU V. S.

1. NAME OF DECEASED [Faint text]		2. DATE OF DEATH [Faint text]	
3. PLACE OF DEATH [Faint text]		4. CAUSE OF DEATH [Faint text]	
5. SEX [Faint text]		6. AGE [Faint text]	
7. OCCUPATION [Faint text]		8. MARITAL STATUS [Faint text]	
9. EDUCATION [Faint text]		10. RELIGION [Faint text]	
11. SOCIAL SECURITY NUMBER [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF DECEASED [Faint text]	
15. SIGNATURE OF WITNESS [Faint text]		16. SIGNATURE OF DECEASED [Faint text]	
17. SIGNATURE OF WITNESS [Faint text]		18. SIGNATURE OF DECEASED [Faint text]	
19. SIGNATURE OF WITNESS [Faint text]		20. SIGNATURE OF DECEASED [Faint text]	
21. SIGNATURE OF WITNESS [Faint text]		22. SIGNATURE OF DECEASED [Faint text]	
23. SIGNATURE OF WITNESS [Faint text]		24. SIGNATURE OF DECEASED [Faint text]	
25. SIGNATURE OF WITNESS [Faint text]		26. SIGNATURE OF DECEASED [Faint text]	
27. SIGNATURE OF WITNESS [Faint text]		28. SIGNATURE OF DECEASED [Faint text]	
29. SIGNATURE OF WITNESS [Faint text]		30. SIGNATURE OF DECEASED [Faint text]	
31. SIGNATURE OF WITNESS [Faint text]		32. SIGNATURE OF DECEASED [Faint text]	
33. SIGNATURE OF WITNESS [Faint text]		34. SIGNATURE OF DECEASED [Faint text]	
35. SIGNATURE OF WITNESS [Faint text]		36. SIGNATURE OF DECEASED [Faint text]	
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39. SIGNATURE OF WITNESS [Faint text]		40. SIGNATURE OF DECEASED [Faint text]	
41. SIGNATURE OF WITNESS [Faint text]		42. SIGNATURE OF DECEASED [Faint text]	
43. SIGNATURE OF WITNESS [Faint text]		44. SIGNATURE OF DECEASED [Faint text]	
45. SIGNATURE OF WITNESS [Faint text]		46. SIGNATURE OF DECEASED [Faint text]	
47. SIGNATURE OF WITNESS [Faint text]		48. SIGNATURE OF DECEASED [Faint text]	
49. SIGNATURE OF WITNESS [Faint text]		50. SIGNATURE OF DECEASED [Faint text]	
51. SIGNATURE OF WITNESS [Faint text]		52. SIGNATURE OF DECEASED [Faint text]	
53. SIGNATURE OF WITNESS [Faint text]		54. SIGNATURE OF DECEASED [Faint text]	
55. SIGNATURE OF WITNESS [Faint text]		56. SIGNATURE OF DECEASED [Faint text]	
57. SIGNATURE OF WITNESS [Faint text]		58. SIGNATURE OF DECEASED [Faint text]	
59. SIGNATURE OF WITNESS [Faint text]		60. SIGNATURE OF DECEASED [Faint text]	
61. SIGNATURE OF WITNESS [Faint text]		62. SIGNATURE OF DECEASED [Faint text]	
63. SIGNATURE OF WITNESS [Faint text]		64. SIGNATURE OF DECEASED [Faint text]	
65. SIGNATURE OF WITNESS [Faint text]		66. SIGNATURE OF DECEASED [Faint text]	
67. SIGNATURE OF WITNESS [Faint text]		68. SIGNATURE OF DECEASED [Faint text]	
69. SIGNATURE OF WITNESS [Faint text]		70. SIGNATURE OF DECEASED [Faint text]	
71. SIGNATURE OF WITNESS [Faint text]		72. SIGNATURE OF DECEASED [Faint text]	
73. SIGNATURE OF WITNESS [Faint text]		74. SIGNATURE OF DECEASED [Faint text]	
75. SIGNATURE OF WITNESS [Faint text]		76. SIGNATURE OF DECEASED [Faint text]	
77. SIGNATURE OF WITNESS [Faint text]		78. SIGNATURE OF DECEASED [Faint text]	
79. SIGNATURE OF WITNESS [Faint text]		80. SIGNATURE OF DECEASED [Faint text]	
81. SIGNATURE OF WITNESS [Faint text]		82. SIGNATURE OF DECEASED [Faint text]	
83. SIGNATURE OF WITNESS [Faint text]		84. SIGNATURE OF DECEASED [Faint text]	
85. SIGNATURE OF WITNESS [Faint text]		86. SIGNATURE OF DECEASED [Faint text]	
87. SIGNATURE OF WITNESS [Faint text]		88. SIGNATURE OF DECEASED [Faint text]	
89. SIGNATURE OF WITNESS [Faint text]		90. SIGNATURE OF DECEASED [Faint text]	
91. SIGNATURE OF WITNESS [Faint text]		92. SIGNATURE OF DECEASED [Faint text]	
93. SIGNATURE OF WITNESS [Faint text]		94. SIGNATURE OF DECEASED [Faint text]	
95. SIGNATURE OF WITNESS [Faint text]		96. SIGNATURE OF DECEASED [Faint text]	
97. SIGNATURE OF WITNESS [Faint text]		98. SIGNATURE OF DECEASED [Faint text]	
99. SIGNATURE OF WITNESS [Faint text]		100. SIGNATURE OF DECEASED [Faint text]	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00184

129

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harwood</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>aa General</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>ELNORA</i> Middle Last <i>Tydings</i>		4. DATE OF DEATH Jan 27 1957	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/22/27</i>
9. AGE (In years last birthday) <i>27</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Sodley Md.</i>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Toshua Watkins</i>	
14. MOTHER'S MAIDEN NAME <i>MAMIE WESTON</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	
16. SOCIAL SECURITY NO. <i>217 344744</i>		17. INFORMANT <i>Wesley Tydings Harwood Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral steman lge</i> 330X DUE TO (b) <i>Ruptured aneurism of middle cerebral artery</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-27-57</i> to <i>1-27-57</i> , that I last saw the deceased alive on <i>1-27-57</i> , 19____, and that death occurred at <i>11:45</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. S. Allen</i>		DATE SIGNED <i>42 Cathedral St 1245</i>	
PHYSICIAN'S NAME (Type) <i>A. T. ALLEN</i>		<i>Annapolis Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/27/57</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Chews Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>West River Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty Salisbury Md</i>		24a. REC'D BY REGISTRAR <i>1/29/57</i>	
ADDRESS <i>42 Cathedral St</i>		24b. REGISTRAR'S SIGNATURE <i>V. Brunch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00185

CERTIFICATE OF DEATH

Reg. Dist. No.

78

187

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 10 months 20 days 05 x 02	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Rt. #1	
3. NAME OF DECEASED (Type or print) First Booker Middle Venable Last Venable		4. DATE OF DEATH Month 1 Day 18 Year 19 57	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY — — — —	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James Red		14. MOTHER'S MAIDEN NAME Jane Red	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 023X (b) Similarity with (c) Dysenteric Ulcers		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease Syphilis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/10 , 19 56 , to 1/18 , 19 57 , that I last saw the deceased alive on 1/18 , 19 57 , and that death occurred at 7:00 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Lionel McHenry Mapp		ADDRESS (Street, city or town, state) Crownsville, Md.	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.		DATE SIGNED 1/18/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) 12-25-57 Mt. Calvary		22c. NAME OF CEMETERY OR CREMATORY Anne Arundel Co. Md.	
22b. DATE THEREOF		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. J. Wilson		24a. REC'D BY REGISTRAR JAN 28 1957	
ADDRESS 1009 E. North Ave. Balto 17 Md.		24b. REGISTRAR'S SIGNATURE A. M. Joyce	

JAN 28 1957

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

130

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TRACYS Landing c. LENGTH OF STAY IN 1b 50 yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY BA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tracey's Landing d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle WALLACE Last WALLACE				4. DATE OF DEATH Month January Day 2 Year 19 57			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 1 1904	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 52 Days 52	IF UNDER 24 HRS. Hours 52 Min. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Tobacco		11. BIRTHPLACE (State or foreign country) Fair Haven Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Wallace				14. MOTHER'S MAIDEN NAME Essie Griffin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 216308483		17. INFORMANT Henrietta Wallace Traceys Landing Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab Wound of Chest DUE TO Conditions, if any, which gave rise to immediate cause (b) 977X (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Stabbed during altercation.							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed during altercation.					
20c. TIME OF INJURY Month, Day, Year 6:45 p.m. 1/2 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tracey's Landing A.A.Co. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/6/57		22c. NAME OF CEMETERY OR CREMATORY Union Chapel	
22d. LOCATION (City, town, or county) (State) Makeedree Md				22e. REC'D BY REGISTRAR 1/10/57			
23. FUNERAL DIRECTOR'S SIGNATURE Barnard Harduty				23b. REGISTRAR'S SIGNATURE 1/10/57			

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

Paul F. Guerin, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

1/3/57

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased		2. Sex		3. Age	
4. Date of Death		5. Time of Death		6. Place of Death	
7. Cause of Death		8. Manner of Death		9. Signature of Medical Examiner	
10. Signature of Coroner		11. Signature of Registrar		12. Signature of Burial Officer	
13. Signature of Undertaker		14. Signature of Funeral Home		15. Signature of Cemetery	
16. Signature of Church		17. Signature of Minister		18. Signature of Rector	
19. Signature of Pastor		20. Signature of Priest		21. Signature of Rabbi	
22. Signature of Imam		23. Signature of Minister of the Gospel		24. Signature of Minister of the Word	
25. Signature of Minister of the Faith		26. Signature of Minister of the Spirit		27. Signature of Minister of the Soul	
28. Signature of Minister of the Body		29. Signature of Minister of the Mind		30. Signature of Minister of the Heart	
31. Signature of Minister of the Hand		32. Signature of Minister of the Foot		33. Signature of Minister of the Head	
34. Signature of Minister of the Neck		35. Signature of Minister of the Arm		36. Signature of Minister of the Leg	
37. Signature of Minister of the Hip		38. Signature of Minister of the Thigh		39. Signature of Minister of the Knee	
40. Signature of Minister of the Ankle		41. Signature of Minister of the Toe		42. Signature of Minister of the Finger	
43. Signature of Minister of the Thumb		44. Signature of Minister of the Nail		45. Signature of Minister of the Hair	
46. Signature of Minister of the Skin		47. Signature of Minister of the Bone		48. Signature of Minister of the Marrow	
49. Signature of Minister of the Blood		50. Signature of Minister of the Lymph		51. Signature of Minister of the Nerve	
52. Signature of Minister of the Muscle		53. Signature of Minister of the Tendon		54. Signature of Minister of the Ligament	
55. Signature of Minister of the Joint		56. Signature of Minister of the Cartilage		57. Signature of Minister of the Bone Marrow	
58. Signature of Minister of the Bone Marrow		59. Signature of Minister of the Bone Marrow		60. Signature of Minister of the Bone Marrow	

RECEIVED
JAN 11 1957
BUREAU V. S.

1

INSTRUCTIONS

TO A **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be completed within 24 hours after death. The uniform copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial-transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00187

CERTIFICATE OF DEATH

188

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>AA</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>SEVERN</u>		<u>4 YRS</u>		TOWN <u>SEVERN</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 366 A</u>				STREET ADDRESS (If rural give location) <u>Box 366 A, Quarterfield Rd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>NINA</u>		(Middle) <u>C</u>		(Last) <u>WATT</u>		(Month) <u>1</u> (Day) <u>17</u> (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M.</u>	8. DATE OF BIRTH <u>OCT 17, 1885</u>	9. AGE last birthday <u>71</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>		11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Michael GAUCH</u>				14. MOTHER'S MAIDEN NAME <u>KATHARINA FURRER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MR Robert WATT, SAME AS 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
200.1 IMMEDIATE CAUSE (A) <u>LYMPHOSARCOMA</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 mos.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April</u> , 19 <u>57</u> , to <u>Jan</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-5-</u> , 19 <u>57</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>C. MacDonald MD</u> M.D.				ADDRESS (Street, city, town, state) <u>Glen Burnie, Md</u>		DATE SIGNED <u>1-17-57</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>CREMATION</u>		DATE THEREOF <u>1/17/57</u>		NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		LOCATION (City, town, or county) <u>BALTO, MD</u>	
24. REC'D BY REGISTRAR <u>VS</u>		REGISTRAR'S SIGNATURE <u>L. J. DeLap</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping + KIRKLEY</u>		ADDRESS <u>Glen Burnie Md.</u>	
DATE							

CERTIFICATE OF DEATH

128

1957

1. PLACE OF DEATH

MARYLAND

2. NAME OF DECEASED

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. DATE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGY

16. SIGNATURE OF BURIAL

17. SIGNATURE OF CREMATION

18. SIGNATURE OF OTHER

19. SIGNATURE OF

20. SIGNATURE OF

21. SIGNATURE OF

22. SIGNATURE OF

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1957

RECEIVED

189

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DRURY</u>				c. LENGTH OF STAY IN 1b <u>30 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) <u>MORGAN BIRKHEAD</u> First <u>WAYSON</u> Middle Last				4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/12/85</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>2</u> Min. <u>1957</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>2</u> Min. <u>1957</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Sodley Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>MORGAN M WAYSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY ELLEN BIRKHEAD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>216326669</u>		17. INFORMANT Address <u>KATHERINE PADGETT, LOTHIAN Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept 1</u> , 195 <u>5</u> , to <u>Jan 2</u> , 195 <u>7</u> , that I last saw the deceased alive on <u>Jan 1</u> , 195 <u>7</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D. <u>Lothian, Md</u>				DATE SIGNED <u>1-3-57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/5/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>		22d. LOCATION (City, town, or county) (State) <u>Owensville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u> ADDRESS <u>Galveston Md</u>				24a. REC'D BY REGISTRAR DATE <u>1/10/57</u>		24b. REGISTRAR'S SIGNATURE <u>W. Russell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

JAN 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00189

131

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY AA MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY V			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn 3 vol-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel Gen. Hosp.				d. STREET ADDRESS 3941 Brooklyn Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First John Middle A. Last Welsh				4. DATE OF DEATH Month 1 Day 17 Year 1957			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 6, 1881		9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY City of Balto.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Thomas Welsh		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple lung abscesses 521X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral artery sclerosis, atherosclerosis							INTERVAL BETWEEN ONSET AND DEATH 2 wks.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/15 , 19 57 , to 1/17 , 19 57 , that I last saw the deceased alive on 4/17 , 19 57 , and that death occurred at 2 p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Annapolis, Md. DATE SIGNED 1/18/57							
ACTUAL SIGNATURE John H. Haden		M.D. 90 Cathedral					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/57		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McGully Funeral Homes 130 E. Fort Ave.				24a. REC'D BY REGISTRAR DATE JAN 21 1957		24b. REGISTRAR'S SIGNATURE Wm. J. French	

CERTIFICATE OF DEATH

131

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1922		5. PLACE OF BIRTH Jackson, Mississippi		6. RACE White		7. MARITAL STATUS Single		8. OCCUPATION None		9. CAUSE OF DEATH Suicide		10. MANNER OF DEATH Homicide		11. PLACE OF DEATH Memphis, Tennessee		12. DATE OF DEATH April 4, 1968		13. TIME OF DEATH 2:01 PM		14. SIGNATURE OF DECEASED None		15. SIGNATURE OF WITNESS None		16. SIGNATURE OF PHYSICIAN None		17. SIGNATURE OF CORONER None		18. SIGNATURE OF JURY None		19. SIGNATURE OF JUDGE None		20. SIGNATURE OF CLERK None		21. SIGNATURE OF REGISTRAR None		22. SIGNATURE OF OTHER None	
23. NAME OF DECEASED JAMES EARL RAY		24. SEX Male		25. AGE 35		26. DATE OF BIRTH May 19, 1922		27. PLACE OF BIRTH Jackson, Mississippi		28. RACE White		29. MARITAL STATUS Single		30. OCCUPATION None		31. CAUSE OF DEATH Suicide		32. MANNER OF DEATH Homicide		33. PLACE OF DEATH Memphis, Tennessee		34. DATE OF DEATH April 4, 1968		35. TIME OF DEATH 2:01 PM		36. SIGNATURE OF DECEASED None		37. SIGNATURE OF WITNESS None		38. SIGNATURE OF PHYSICIAN None		39. SIGNATURE OF CORONER None		40. SIGNATURE OF JURY None		41. SIGNATURE OF JUDGE None		42. SIGNATURE OF CLERK None		43. SIGNATURE OF REGISTRAR None		44. SIGNATURE OF OTHER None	

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JAN 21 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G210 1-29-57 et

190

CERTIFICATE OF DEATH

00190

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crownsville</i>		c. LENGTH OF STAY IN 1b <i>4 months</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Crownsville State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mamie</i> First <i>White</i> Middle <i>White</i> Last <i>White</i>		4. DATE OF DEATH <i>January 19 1957</i> Month <i>January</i> Day <i>19</i> Year <i>1957</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-17-55</i>
9. AGE (In years last birthday) <i>12</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>Millie White (Montgomery)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Increased intracranial pressure</i> 344X DUE TO <i>Hydrocephaly</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO <i></i> (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Emaciation</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-1-1956</i> to <i>1-19-1957</i> , that I last saw the deceased alive on <i>1-19-1957</i> , and that death occurred at <i>5:10 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. Weber</i> M.D.		ADDRESS (Street, city or town, state) <i>Crownsville State Hosp</i> DATE SIGNED <i>1/20/57</i>	
PHYSICIAN'S NAME (Type) <i>KONSTANTIN WEBER</i>		<i>Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/24/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Williamsonburg Co. S.C.</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William L. Stetson</i> ADDRESS <i>1701 N. McCall St. Baltimore, Md.</i>		24. REG'D BY REGISTRAR <i>22 JAN 22 1957</i> 24b. REGISTRAR'S SIGNATURE <i>R. M. Joyce</i>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00191

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anne Arundel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Meade</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Jessups</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. STREET ADDRESS <u>2000 feet east of route 8 Md.</u>							
3. NAME OF DECEASED (Type or print) <u>Hugh E. Wilson</u>				4. DATE OF DEATH <u>January 21st. 1957</u>			
5. SEX <u>M.</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>7/9/31</u>				9. AGE (in years last birthday) <u>25 yrs.</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sergeant in the U.S. Army</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Verbana, Alabama</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>Irene Wilson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes at present</u>				16. SOCIAL SECURITY NO. <u>Fort Meade's Records.</u>			
17. INFORMANT <u>Fort Meade's Records.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>823X</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile hit a post and turned over</u>			
20c. TIME OF INJURY Month, Day, Year <u>1.55 a.m. 1/21/57 19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 8 Md.</u>				20f. (City or town) <u>Jessups, A.A. Md.</u> (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Gustave H. Faubert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/21/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>1/28/57</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Morning Star</u>				22d. LOCATION (City, town, or county) <u>Verbana</u> (State) <u>Alabama</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips</u>				ADDRESS <u>1808 N. Monroe St Baltimore, Md</u>			
24a. REC'D BY REGISTRAR <u>21 Jan 57</u>				24b. REGISTRAR'S SIGNATURE <u>W.L. Saylor</u> 1/Lt MSC			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

JAN 28 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DEALE</u>		c. LENGTH OF STAY IN 1b <u>60 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>DEALE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM BRYSON</u> <u>Wood</u>		4. DATE OF DEATH Month Day Year <u>1</u> <u>3</u> <u>1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 24 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chorochton Md.</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Richard F. Wood</u>		14. MOTHER'S MAIDEN NAME <u>Caroline E. Simmons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218035023</u>	
17. INFORMANT <u>LLOYD F. WOOD, DEALE MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> DUE TO (b) <u>hypertension</u> DUE TO (c) <u>generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>332X</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-20</u> , 19 <u>55</u> , to <u>Jan 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Dec 28</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emily A. Nelson</u>		ADDRESS (Street, city or town, state) <u>Cathon, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Bernard Hardisty Galbreath</u>		DATE SIGNED <u>1-3-57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/4/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST JAMES</u>		22d. LOCATION (City, town, or county) (State) <u>TRACYS Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty Galbreath</u>		ADDRESS <u>110/57</u>	
24a. REC'D BY REGISTRAR <u>U. O. Branch</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARY AND STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

BUREAU V. S.

AN 11 1957

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